THE COUNTRY LAWYER, P.C.
741 East Fry Blvd.
Sierra Vista, Arizona 85635
(520) 459-6400
FAX: (520) 459-2540
perry@thecountrylawyer.com

PERRY HICKS
Attorney for Plaintiff
State Bar No. 007695

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF COCHISE

RAMONA AMAYA, mother of deceased, Reynaldo Amaya

Plaintiff,

vs.

COCHISE COUNTY SHERIFF MARK DANNELS,

Defendant.

NO. CV201600305

PLAINTIFF'S CONTROVERTING STATEMENT OF FACTS IN OPPOSITION TO DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

DIV. FOUR

Many of the statements in Defendant Sheriff Dannel's Separate Statement of Facts in Support of Motion for Summary Judgment are unsupported by affidavit or other materials permitted by Ariz.R.Civ.P. 56(e). Plaintiff does not concede these, and enumerates below those statements with which she particularly takes issue. Her primary objection, however, is not to the facts that Defendant states, but to the facts that Defendant omits. These additional facts, supplied by Plaintiff hereinafter, are of critical relevance to the determination whether Defendant's treatment of Reynaldo Amaya met the standard of care.

1. Plaintiff objects to Defendant's characterizations of the evidence in ways which are inconsistent with the record. This includes Defendant's paragraph #6, to the effect that "Upon Reynaldo's arrival at the jail, Sergeant Figueroa had a detailed conversation with Reynaldo." The evidence is that the conversation was not at all detailed with respect to Mr. Amaya's concern about the "hit" that he believed awaited him in state prison, as to which

Sergeant Figueroa testified that he responded "Don't even think about that." (Exhibit 1, Deposition of Detention Sergeant Fernando Figueroa, p. 31:14.

2. Plaintiff similarly objects to Defendant's paragraph #13, to the effect that Mr. Amaya's request for separation from other inmates "evidences a desire for self-preservation, which is contrary to an intent to commit suicide." Defendant provides no citation to the record for this statement, which is mere argument or conjecture. Also with respect to this paragraph, Plaintiff disputes the allegedly undisputed statement "Reynaldo was provided the segregation and protective custody" to the extent it implies that other inmates were successfully kept away from Mr. Amaya or that he was successfully protected from their threats.

3. Plaintiff objects to the additional statement in paragraph #13 that jail Classification Officer Jose Quintana asked Mr. Amaya about suicide and he said "No." The document referenced by Defendant evidences that Officer Quintana entered the answer "No" to the question "Is the inmate a suicide risk?" It does not establish what conversation Officer Quintana held with Mr. Amaya or the basis on which Officer Quintana arrived at his determination. (Exhibit 2, Reynaldo Amaya Classification File, p. 7; parts of same document provided by Defendant as Exhibit 3 to his Separate Statement of Facts in Support of Motion for Summary Judgment.)

4. Plaintiff objects to paragraph #16 to the extent that the allegedly undisputed statement "corrections officers made their rounds involving Reynaldo's cell approximately every 30 minutes" implies that the actions of officers walking past Mr. Amaya's cell constituted "making rounds" in compliance with the requirements of jail policy. Policy required that even for inmates not on special watch, officers were to "visually inspect every individual cell." (Exhibit 3, Policy D.034, 1.2.1.) Lindsay M. Hayes, a nationally recognized expert and consultant in the field of suicide prevention in correctional facilities, states in the attached affidavit that "CCTV surveillance recording of North D Pod on June 16, 2015

indicates that detention officers often simply glanced at, and did not stop and look directly into, Mr. Amaya's cell during the more than two-hour period from approximately 2:04 to 4:42 PM." (Exhibit 4, Affidavit of Lindsay M. Hayes, ¶4.)

5. Plaintiff objects to the statement in paragraph #17 that the jail videos show Mr. Amaya moving in his cell about 19 minutes before he was found hanged. Defendant's citation for this statement is to the Initial Expert Report of Sean T. Stewart. Defendant has provided no affidavit from Mr. Stewart. Such a report would not be admissible at trial without the testimony of the expert in question, and this unsworn report is therefore not admissible in support of summary judgment. Ariz.R.Civ.P. 56 (c).

Plaintiff provides the following additional material facts, supported by the referenced documents and recordings attached as Exhibits hereto. With the exception of the deposition excerpts and the affidavit of Lindsay M. Hayes and its attachment, all of the Exhibits are records provided by Defendant. Defendant has admitted in response to Requests for Admissions that the various records it has produced, and which Plaintiff relies on herein, are accurate copies of records held in the Cochise County Sheriff's Office, that events documented therein were recorded at or near the time of their occurrence by persons with knowledge thereof and in the regular course of activities conducted by said Office, and that statements made in said records by deputies and officers of said Office were made by them within the scope of their employment.

6. After his arrest on the night of June 14, 2015, Mr. Amaya asked what he was being charged with. (Exhibit 6, Deposition of Trooper Philip Hogan, p.17:21-23.) Told by Deputy Hogan that his previous criminal history would determine whether he would be charged with a misdemeanor or a felony, Mr. Amaya asked Deputy Hogan if he would obtain that history. Mr. Amaya was placed in a holding cell at the Sheriff's Douglas substation

while Deputy Hogan waited for the requested information. (Id.; Exhibit 5, audio recording #1122-2, beginning at 10:15 and at 12:15.)

7. In the holding cell Mr. Amaya became agitated and began hitting his head with his handcuffs. (Exhibit 6, Deposition of Trooper Philip Hogan, p.18:15-17.) When asked what was wrong, Mr. Amaya responded with statements including "I just want to know whatever you're going to charge me," and "I'm going to start f***ing myself up if you don't take me now." (Exhibit 5, audio recording #1122-2, beginning at 14:03.)

8. Deputy Hogan then moved the handcuffs from Mr. Amaya's front to his back, at which point Mr. Amaya threatened to continue injuring himself by slamming his head against whatever was available. Deputy Clark arrived in response to Deputy Hogan's radio communication about Mr. Amaya's self-injury, and observed that Mr. Amaya's forehead was bright red. (Exhibit 6, Deposition of Trooper Philip Hogan, p.19:2-6; Exhibit 7, Deposition of Deputy Roger Clark, pp.17:16 - 18:6; Exhibit 5, audio recording #1122-2, beginning at 14:27; Exhibit 9, Deputy Philip Hogan Narrative Report, p.3.)

9. Deputy Hogan placed Mr. Amaya in the back of a patrol car parked at the substation to secure him while he completed his paperwork. As they went to the car, Mr. Amaya returned to the theme of felonies: "If you had told me felony, I still would have turned myself in." "If you're going to charge me with a felony, just do it." (Exhibit 6, Deposition of Trooper Philip Hogan, p.19:5-6; Exhibit 5, audio recording #1122-2, beginning at 15:33.)

10. As Deputy Hogan seated him in the patrol car, Mr. Amaya stated, "I'm still going to bust my f***ing grill open, watch." Mr. Amaya proceeded to bang his head against the metal interior and windows of the passenger compartment, an incident which was witnessed by Deputy Clark. Told to "knock it off," Mr. Amaya said Deputy Hogan could

charge him "with ten felonies. I don't give a f***. I'm still going back to prison. I'm on parole anyways. I just wanted to know." "I'll f*** myself up more." After Deputy Hogan told Mr. Amaya to "chill out," he responded, "It's not like I'm f***ing scared, I'm the one that called and turned myself in." Moments later, he observed "I'm gonna f***ing have a hard time the whole motherf***ing way, watch." (Exhibit 6, Deposition of Trooper Philip Hogan, pp.19:24 - 20:7, p.31:11-13; Exhibit 7, Deposition of Deputy Roger Clark, p.20:17-21; Exhibit 5, audio recording #1122-2, beginning at 15:58; Exhibit 9, Deputy Philip Hogan Narrative Report, p.3; Exhibit 8, video recording #1122-1 beginning at 00:32, at 2:20, and at 5:46.)

11. Deputy Hogan asked a Douglas police officer to watch Mr. Amaya in the parked vehicle while he completed his paperwork. (Exhibit 6, Deposition of Trooper Philip Hogan, p.20:8-12, p.31:14-18, p. 39:19-21; Exhibit 9, Deputy Philip Hogan Narrative Report, p.3.)

12. Afterwards Deputy Hogan returned to the vehicle to drive Mr. Amaya to the jail. (Exhibit 6, Deposition of Trooper Philip Hogan, p.20:24-25). Mr. Amaya asked again what he was being charged with. Deputy Hogan responded, "I'll let you know when we get over there." When Mr. Amaya asked him why, Deputy Hogan responded "I'll let you know when we get over there because I don't want you to be beating your head." He did however proceed to inform Mr. Amaya that among other offenses, he was being charged with "aggravated domestic violence, felony; aggravated harrassment, felony." Mr. Amaya observed, "Charging me with a felony, going back to prison." En route to the jail, he continued to question Deputy Hogan about what class the felonies were. (Exhibit 8, video recording #1122-1 beginning at 1:02:37 and at 1:17:56.)

13. While Officer Hogan and Mr. Amaya were on their way to the jail, Deputy Clark phoned the booking officer at the jail, Benjamin Acuña, and advised him to place Mr.

Amaya on suicide watch. (Exhibit 7, Deposition of Deputy Roger Clark, pp. 21:3 - 22:6.) When asked why, he responded, "Because someone banging his head that hard needs to be watched closely." (Exhibit 7, Deposition of Deputy Roger Clark, p. 23:3-8; Exhibit 17, Memorandum from Detention Lieutenant Ariel Monge, p. 2.) He followed up with a text message to Deputy Hogan, stating "I advised detention of his actions and requested someone standing by for you and suicide watch for him." (Exhibit 7, Deposition of Deputy Roger Clark, p.24:5-20 and Exhibit No.2 to Deposition.)

14. Deputy Clark was aware, on the basis of conversations with other Sheriff's employees and with Mr. Amaya himself, that Mr. Amaya had been shot a few years earlier, that he had testified against the man who shot him, "Cheech," and that Cheech had been convicted in the shooting. Deputy Clark knew that Mr. Amaya had suffered a wound to his stomach area, and that "someone did not welcome [Mr. Amaya] back to prison." (Exhibit 7, Deposition of Deputy Roger Clark, pp.6:22-8:23.) Mr. Amaya still suffered the effects of the bullet wounds. He had initially been handcuffed in front instead of in back because he told Deputy Hogan that he had been shot in the hand and had pins in his hand. (Exhibit 6, Deposition of Trooper Philip Hogan, p.19:2-6; pp.39:22 - 40:20; Exhibit 5, audio recording #1122-2, beginning at 2:33.) At medical intake at the jail, he reported digestive problems due to the bullet wound to his abdomen. (Exhibit 10, Cochise County Jail Medical Intake Screening, p.1.)

15. On arrival at the jail Mr. Amaya was seen by Detention Sergeant Fernando Figueroa and the booking officer, Benjamin Acuña. Once again he expressed concern about what would happen to him in prison, Sergeant Figueroa testifying in his deposition that "I remember him saying about having a green light in the state level if he goes over there . . . ." "Green light" was an "inmate term for a hit." (Exhibit 1, Deposition of Detention Sergeant Fernando Figueroa, p.31:8 - 32:7.) Sergeant Figueroa further recalled in a written

memo that Mr. Amaya told him at that time that "he was apprehensive on going back to DOC because he really thought that this time someone was going to complete the hit placed on him in DOC," and that he wondered if he could do his time in jail instead of prison. (Exhibit 12, Memorandum from Sgt. F. Figueroa, p. 2.) Officer Acuña likewise testified that Mr. Amaya told him "that someone had shot him and he testified against that individual; and due to that, as a retaliatory action, that they placed a hit on him." (Exhibit 11, Deposition of Detention Officer Benjamin Acuña', p.33:6-17.) Mr. Amaya also told Officer Acuña that when he had been in the Department of Corrections, he was constantly being physically assaulted. (Exhibit 13, Memorandum from Detention Officer Benjamin Acuña, p.1.)

16. The record of Mr. Amaya's classification at the jail later that morning indicates "has enemies in this facility," "keep separate from all jail population," "safety lock down," and that Mr. Amaya was to be put in protective custody at his own request "due to issues at ADC." (Exhibit 2, Reynaldo Amaya Classification File, pp. 1-4, 7. Nevertheless, after his suicide a note was found in his cell bearing a picture of a rat and the words "I smell a . . . " (Exhibit 14, Property and Evidence Control Sheet; Exhibit 15, Photograph from Reynaldo Amaya's jail cell.)

17. At the jail, Deputy Hogan printed out and delivered the booking paperwork, including the Officer's Statement of Probable Cause, which said:

> I went in to speak with AMAYA and he began to hit his head with the handcuffs and state he would start hitting his head against the walls. He was detained in the handcuffs behind his back and secured in my patrol unit where he began to hit his head in the metal prisoner compartment.

(Exhibit 6, Deposition of Trooper Philip Hogan, pp. 29:17 - 30:7; Exhibit 16, Booking Documents Including Officer's Statement of Probable Cause.

18. Jail policy required that the booking officer complete a sixteen-question intake assessment, the second question of which was "Does the arresting officer believe the inmate is suicidal?" That intake assessment was never done in this case, as was determined by an internal investigation subsequent to Mr. Amaya's suicide. (Exhibit 17, Memorandum from Detention Lieutenant Ariel Monge, p.1 ¶2, p.2 ¶8, p. 3 ¶¶2-4; Exhibit 18, Conclusion of Administrative Investigation 15-006A; Exhibit 19, Interview with Detention Officer Benjamin Acuña, p. 2 ¶5, p.3 ¶5.)

19. Jail policy also required that "Before accepting custody of an arrestee, the Booking Officer will request from the transporting officer any information known to him/her which would be relevant and necessary to safely and securely process and house the arrestee." (Exhibit 20, Policy D.042, 3.5.0).

20. Neither Officer Acuña nor Sergeant Figueroa had any substantive conversation with Deputy Hogan at the jail. (Exhibit 1, Deposition of Detention Sergeant Fernando Figueroa, p.26:16-18; Exhibit 11, Deposition of Detention Officer Benjamin Acuña pp.13:22 - 14:2; pp.16:19 - 17:4; Exhibit 19, Interview with Detention Officer Benjamin Acuña, p.2 ¶3.)

21. The conclusion of the aforementioned internal investigation was that "Officer Acuña neglected the responsibilities of his booking assignment without providing a legitimate reason or excuse." The policies violated included relevant portions of D.042, Booking, Intake, Identification and Consular Notifications, and D.006, Suicide Prevention. (Exhibit 18, Conclusion of Administrative Investigation 15-006A, p.1 end of ¶3, and *passim.*)

22. Mr. Amaya had been in the Cochise County Jail in January of 2012. The records of that incarceration indicate that "I/M [inmate] tried to hurt himself while in custody at DG POE [Douglas Port of Entry] and SW-30 [special watch, every 30 minutes] has been

implemented." (Exhibit 21, 2012 Risk Assessment.) Sergeant Figueroa was one of the officers who checked on Mr. Amaya at that time and recorded his condition on the Observation Sheet indicating that Mr. Amaya was on Special Watch because of "suicidal attempts." (Exhibit 22, 2012 Cochise County Jail Observation Sheet; Exhibit 1, Deposition of Detention Sergeant Fernando Figueroa, pp. 36:23 - 37:5.) In his deposition, Officer Acuña stated that records of previous incarcerations were available at the jail, but he did not testify that he consulted them when booking Mr. Amaya that night. (Exhibit 11, Deposition of Detention Officer Benjamin Acuña, pp. 19:8 - 20:5.)

23. Pursuant to the jail's Suicide Prevention Policy, any detention officer was authorized to initiate a "special watch." (Exhibit 23, Policy D.006, 3.2.0, 4.1.0; Exhibit 11, Deposition of Detention Officer Benjamin Acuña, p. 11:17-18.) The Initial Assessment, which was not done in this case, was to be utilized to ask the arresting officer for his opinion. (Exhibit 23, Policy D.006, 8.3.0 - 8.3.1.) The initial assessments were to be reviewed daily by the Behavior Health Coordinator. (Exhibit 23, Policy D.006, 8.6.0.) The policy provided that "No suicidal gesture can be ignored." (Exhibit 23, Policy D.006, 6.1.3.5), and that officers in doubt at booking should consult with the Behavior Health Coordinator. (Exhibit 23, Policy D.006, 8.2.5.)

24. Neither Sergeant Figueroa nor Detention Officer Acuña consulted with the Behavior Health Coordinator or other mental health professional, despite Sergeant Figueroa's deposition testimony that a mental health professional was available and would have come to the jail that night if called. (Exhibit 1, Deposition of Detention Sergeant Fernando Figueroa, Fig pp.42:14 - 44:3.)

25. Classification officer Jose Quintana and jail personnel responsible for medical screening documented assessments of Mr. Amaya during the day of June 15, 2015, subsequent to his intake and booking by Sergeant Figueroa and Detention Officer Acuña.

(Exhibit 2, Reynaldo Amaya Classification File; Exhibit 10, Cochise County Jail Medical Intake Screening.)

26. Cochise County Jail procedures provided that certain inmates who were considered possible suicide risks could be placed on thirty-minute observation periods. (Exhibit 23, Policy D.006, 6.1.3, 6.1.3.1.) Such inmates were to be placed in lower level housing units (Exhibit 23, Policy D.006, 6.1.3.6), and officers were to encourage them to converse with them (Exhibit 23, Policy D.006, 4.4.0). Officer Acuña testified in his deposition that in the case of a 30-minute suicide watch, detention officers were to take particular note of the inmate when doing their security checks, and make a notation as to the condition of the inmate at that time. (Exhibit 11, Deposition of Detention Officer Benjamin Acuña, pp. 25:24 - 26:8, p. 28:14-22; see also Exhibit 1, Deposition of Detention Sergeant Fernando Figueroa 21:14-18.)

27. Mr. Amaya was housed in an upper-level cell, where he had access to bed sheets and to an elevated wall vent to which he could attach strips torn from the sheets. It was in that cell, on June 16, 2015, that he killed himself. (Exhibit 24, Incident Report, Detention Officer M. Orozco.)

28. In his affidavit, jail suicide prevention expert Lindsay Hayes states that "CCTV surveillance recording of North D Pod on June 16, 2015 indicates that detention officers often simply glanced at, and did not stop and look directly into, Mr. Amaya's cell during the more than two-hour period from approximately 2:04 to 4:42 PM. As such, it is dubious whether officers actually saw the inmate during all of these 30-minute cell checks." (Exhibit 4, Affidavit of Lindsay M. Hayes, ¶4.)

29. Mr. Hayes is further of the opinion that observation of some suicidal inmates at 30-minute intervals is "grossly inadequate and well below the standard of care and

contrary to national correctional standards that required observation between constant and continuous through staggered intervals that do not exceed fifteen minutes." (Exhibit 4, Affidavit of Lindsay M. Hayes, ¶6.) National standards further require suicidal inmates to be housed in cells without protrusions of any kind that would enable the inmate to hang himself/herself. Id.

30. Mr. Hayes is of the opinion that the decision of Sergeant Figueroa not to place Mr. Amaya on suicide precautions as requested by other Cochise County Sheriff's Office personnel, as well as the failure to refer him to a mental health professional, was in violation of the jail's suicide prevention policy, contrary to the standard of care, and a proximate cause of Mr. Amaya's suicide the following day. (Exhibit 4, Affidavit of Lindsay M. Hayes, ¶5.)

RESPECTFULLY SUBMITTED this 9 day of November, 2018.

THE COUNTRY LAWYER, P.C.

By Perry Hicks
PERRY HICKS
Attorney for Plaintiff

Original of the foregoing and exhibits
filed with the Cochise County Clerk of the Court
and a copy mailed/delivered
this 9 day of November, 2018, to:

Daryl A. Audilett, Attorney at Law
AUDILETT LAW PC
335 North Wilmot Road #500
Tucson, AZ 85711-2636
Attorney for Defendant

Hon. Karl D. Elledge

EXHIBITS

1 Deposition of Detention Sergeant Fernando Figueroa, excerpted

2 Reynaldo Amaya Jail Classification File

3 Cochise County Sheriff's Office, Detention Division, Policy D.034, Proxipen Guard Tour System, excerpted

4 Affidavit of Lindsay M. Hayes, with Attachment A

5 Audio recording #1122-2, on separate CD

6 Deposition of Trooper Philip Hogan, excerpted

7 Deposition of Deputy Roger Clark, excerpted

8 Video recording #1122-1, on separate CD

9 Narrative Report , Deputy Philip Hogan

10 Cochise County Jail Medical Intake Screening

11 Deposition of Detention Officer Benjamin Acuña, excerpted

12 Memorandum from Sgt. F. Figueroa

13 Memorandum from Detention Officer Benjamin Acuña

14 Property and Evidence Control Sheet

15 Photograph from Reynaldo Amaya's jail cell

16 Booking Documents Including Officer's Statement of Probable Cause

17 Memorandum from Detention Lieutenant Ariel Monge

18 Conclusion of Administrative Investigation 15-006A

19 Interview with Detention Officer Benjamin Acuña

20 Cochise County Sheriff's Office, Detention Division, Policy D.042, Booking and Intake, excerpted

21 2012 Risk Assessment

22 2012 Cochise County Jail Observation Sheet

23 Cochise County Sheriff's Office, Detention Division, Policy D.006, Suicide Prevention

24 Incident Report, Detention Officer M. Orozco

EXHIBIT 1

IN THE SUPERIOR COURT OF THE STATE OR ARIZONA

COUNTY OF COCHISE

RAMONA AMAYA, mother of deceased Reynaldo Amaya, Plaintiff, vs. COCHISE COUNTY SHERIFF MARK DANNELS, Defendant.	No. CV201600305

DEPOSITION OF

FERNANDO FIGUEROA

April 26, 2018

Sierra Vista, Arizona

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Colville & Dippel, LLC
(520) 884-9041
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Arizona RRP No. R1129

REPORTED BY: NANCY P. RICHMOND, RPR
Arizona CR No. 50864

are you okay? You need anything? You're okay?" And, you know, have him -- see what answers he gives and stuff like that.

Q. And a fifteen-minute watch, what other watches were there, what other types of watches?

A. There's a fifteen, and the regular is a thirty minute. Now, we've had people on five-minute watches, but those people had tried to kill themselves and we saved them, so -- and five-minute watch, sometimes we had an officer sitting in front of an inmate, right in front of their cells for twenty-four hours after they tried to commit suicide. But those are extreme cases.

Mostly the regular watch is thirty minutes, and they make sure the inmate's moving, and, you know, they talk to him every thirty minutes. And at night they make sure they look at skin. They're breathing.

MR. AUDILETT: What about -- sorry to interrupt, but just in the interests of full disclosure, what about the use of the restraining chair?

A. Oh, restraining chairs are inmates that, like, had a situation. Inmate went straight full into the wall, head first. So I put him in a

Q. It's a fairly short report?

A. I would say so, yeah. That's it.

Q. Did you review anything else for this deposition?

A. I heard the -- when he came in, you showed me --

MR. AUDILETT: The audio.

Q. The audio of when Reynaldo --

A. Yeah. That's when I recall --

MR. AUDILETT: You're jumping in a little too soon, just before he's finished. And she's going to reach out and --

THE WITNESS: Oh, yeah. Sorry.

MR. AUDILETT: -- remind you.

THE WITNESS: I'm too close to her. She's going to punch me.

MR. AUDILETT: There you go. You're doing otherwise very good.

Q. Who was present when Reynaldo Amaya was brought to the jail by Officer Hogan?

A. I mean, my staff?

Q. Yes.

A. It was me, Acuña, Drogvolds.

MR. AUDILETT: You got to spell that.

A. D-R-O-G-V-O-L-D-S.

Q. And what was Drogvolds?

A. He's just a line officer. I think he was in training at that time. I'm not sure. We were training him. Can't remember the other officers. Acuña, did I say?

Q. Right, yes. You, Acuña, Drogvolds?

A. And I can't remember the other guys.

Q. Okay. And you were the sergeant?

A. Yeah, I was the OIC in charge.

Q. And Acuña was the booking officer?

A. Acuña was the booking officer.

Q. And Drogvolds was a regular officer?

A. There was a regular line officer. There was a couple officers, but I can't remember who it was.

Q. Did you talk to Officer Hogan that night to get his information on the inmate?

A. Not that I recall.

Q. Do you recall or did you talk to -- what's the other guy?

MS. BERNSTEIN: Clark.

MR. AUDILETT: Roger Clark.

Q. -- Roger Clark that night to get his information?

A. No. Control, I guess, he called the

MR. HICKS: You wouldn't know anything about that, would you, Daryl?

A. He's a good kid.

MR. AUDILETT: Karen is my memory.

Q. So Benjamin was talking to Reynaldo at the same time you were, more or less?

A. Yeah. Yeah, I would say that.

Q. Other than the things you've told us, do you recall anything else that you asked Reynaldo or that he told you?

A. I remember him saying about having a green light in the state level if he goes over there, and I told him, "You don't know if you're going to go there yet. Don't even think about that." You know, I assured him that if he did go, you know, he needs to talk to classification, make sure that they place him in the proper areas and, you know, keep him safe and stuff like that. But, I mean, he was -- he was fine. That night he was fine. Can't believe he did that, you know, couple days later.

Q. What is a green light?

A. Green light in the Department of Corrections, that's a inmate term for a hit.

Q. So it's an inmate term for somebody has put a hit out on him?

A. Hm-hmm.

Q. Somebody within --

MR. AUDILETT: You have to say yes.

A. Yes.

Q. Someone within -- another inmate within the Department of Corrections, usually?

A. Usually, yes.

Q. And did he explain to you who had put a hit out on him?

A. No.

Q. Were you familiar with Reynaldo being shot a few years prior to that?

A. I think I heard something about that.

Q. Do you know who Cheech is?

MS. BERNSTEIN: Altamirano?

A. No, never heard of him.

Q. But you knew that someone within the Department of Corrections had had -- Reynaldo told you that someone within --

A. Reynaldo told me, but I have no idea who would -- why and who, you know.

Q. Did you have any knowledge that there was anyone within the jail itself or did he tell you that there was anyone within the jail itself that had possibly --

A. I don't recall that.

Q. You don't recall it?

A. No.

Q. A time where he had apparently done something coming through the port of entry and had been placed in the hospital for suicidal tendencies, and then when he was transferred to the jail, it was a suicide watch?

A. That's a long time ago.

Q. Jail records from that incident in 2012, are you familiar with what observation sheets are?

A. Yeah, medical and special watch sheets.

Q. Special watch sheets, like for suicidal attempts, things like that?

A. I remember them, yeah.

Q. And --

A. I don't know if they do the same sheet that they used to do when I used to work there, but I remember them.

Q. I'm referring to when he came into the jail --

A. Oh, yeah.

Q. -- in 2012. Were you -- was your I.D. number 815?

A. 815, yeah. That was my call number.

Q. So if the records indicate that officer 815 was one of the officers on January 18th of 2012 that participated in suicide watches on Reynaldo, would that indicate you?

A. 815, yes.

Q. Was your number 815 throughout the time that you worked at the jail?

A. No.

Q. When did it become 815?

A. Sergeant Wolkin had it before me.

Q. Do you remember when you got it?

A. When I became a sergeant. I don't remember exact date.

MR. AUDILETT: Do you remember the year?

THE WITNESS: I can't -- let me --

Q. But when you became sergeant?

A. 2006, maybe. I can't remember.

Q. Okay. You became 815, so in 2012 you would have been officer 815?

A. Yes, yes, yes.

Q. But you don't recall participating in a suicide watch on Reynaldo at that time?

A. Oh, no. We had -- I mean, I had probably couple thousand of them, you know.

Q. But that would not be done during the intake process?

A. Very rarely. Not while I was supervisor.

Q. You don't recall a time when you did that?

A. Oh, no.

Q. Okay.

A. Very rarely. That was a call for the lieutenant or commander. We would tell them the situation, and they would make that decision. You know what? Or HRC, the mental health liaison we had there.

Q. How would they receive that information?

A. The lieutenant?

Q. No. Well, how would -- let's say that Reynaldo came in and you assessed that he was suicidal. Would you involve medical personnel in that?

A. We would actually call the Cenpatico, and they would send a mental health evaluator, and they would talk to the individual. And they would say, "You know what? He needs to go. Call the lieutenant," or, "You know what? Just leave him on a watch. He's going to be okay. You know, I'll check him in a couple days," and stuff like that.

Q. And Cenpatico is what the old CEBUS used

to be?

A. I guess, yes.

Q. And when would they come out? They wouldn't come out that night? They would --

A. Oh, yeah.

Q. They would come out --

A. 3:00 in the morning, 2:00 the morning, they would come out. They were actually pretty good at doing that, so.

Q. How often did they come out when you had assessed an inmate as a possible suicide risk?

A. How many times that happened? I have no idea.

Q. Would they come out every time that you assessed the patient as a suicide risk?

A. Oh, yeah. Only couple times they'd say, you know what? I'll be there -- it was 2:00 in morning. I'll be there at 6:00 or 8:00, you know. I got another patient or -- but they were pretty consistent.

Q. So if you assessed Reynaldo as a suicide risk, then Cenpatico would have sent a mental health professional to the jail to assess him themselves?

A. That night.

Q. Within that night or within a few hours?

A. **Hm-hmm.**

MR. AUDILETT: Say yes.

A. **Yes. I caught myself. Yes.**

MR. AUDILETT: I'm here to catch you.

THE WITNESS: Sorry.

Q. When a person is placed on a suicide watch, do you remove items from them that they might be able to hurt themselves with?

A. **Yes.**

Q. And what are --

A. **Sometimes.**

Q. When you did, what are the items that were removed?

A. **Depends on how severe he was acting suicidal.**

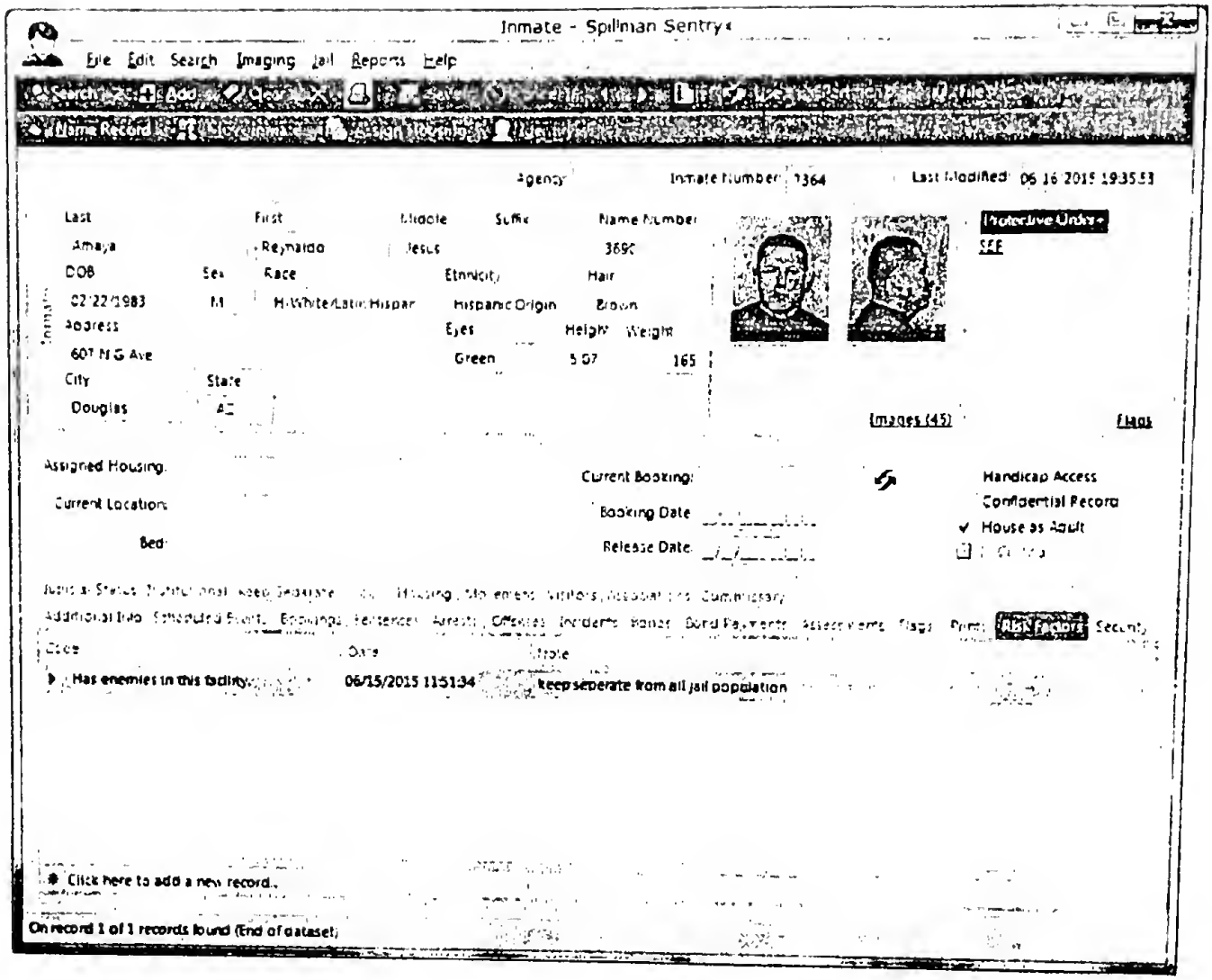
Q. Did you remove sheets?

A. **Yeah. When we removed sheets, all their property is when they would bang their head in the wall or cut their wrists. They'd been in the restraint chair for a little bit. And that's when we would remove everything from there, just leave the mat.**

Q. Even the mat?

A. **We would leave the mat and move -- remove everything.**

EXHIBIT 2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File Edit Search Imaging Jail Reports Help
Search Add Clear Save
Name Record Charges Assign Housing Detail
Agency
Inmate Number 1364
Last Modified 06 16 2015 193553
Last
Amaya
First
Reynaldo
Middle
Jesus
Suffix
Name Number
3690
Protective Units
SEE
DOB
02/22/1983
Sex
M
Race
H-White/Latin Hispar
Ethnicity
Hispanic Origin
Hair
Brown
Address
607 N G Ave
Eyes
Green
Height
5 07
Weight
165
City
Douglas
State
AZ
Images (45)
Flags
Assigned Housing:
Current Location:
Bed:
Current Booking:
Booking Date
Release Date
Handicap Access
Confidential Record
House as Adult
Additional Info
Scheduled Events
Bookings
Sentences
Arrests
Offenses
Incidents
Bonds
Bond Payments
Assessments
Flags
Print
Alert Factors
Security
Code
Date
Note
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06/15/2015 115134
Keep seperate from all jail population
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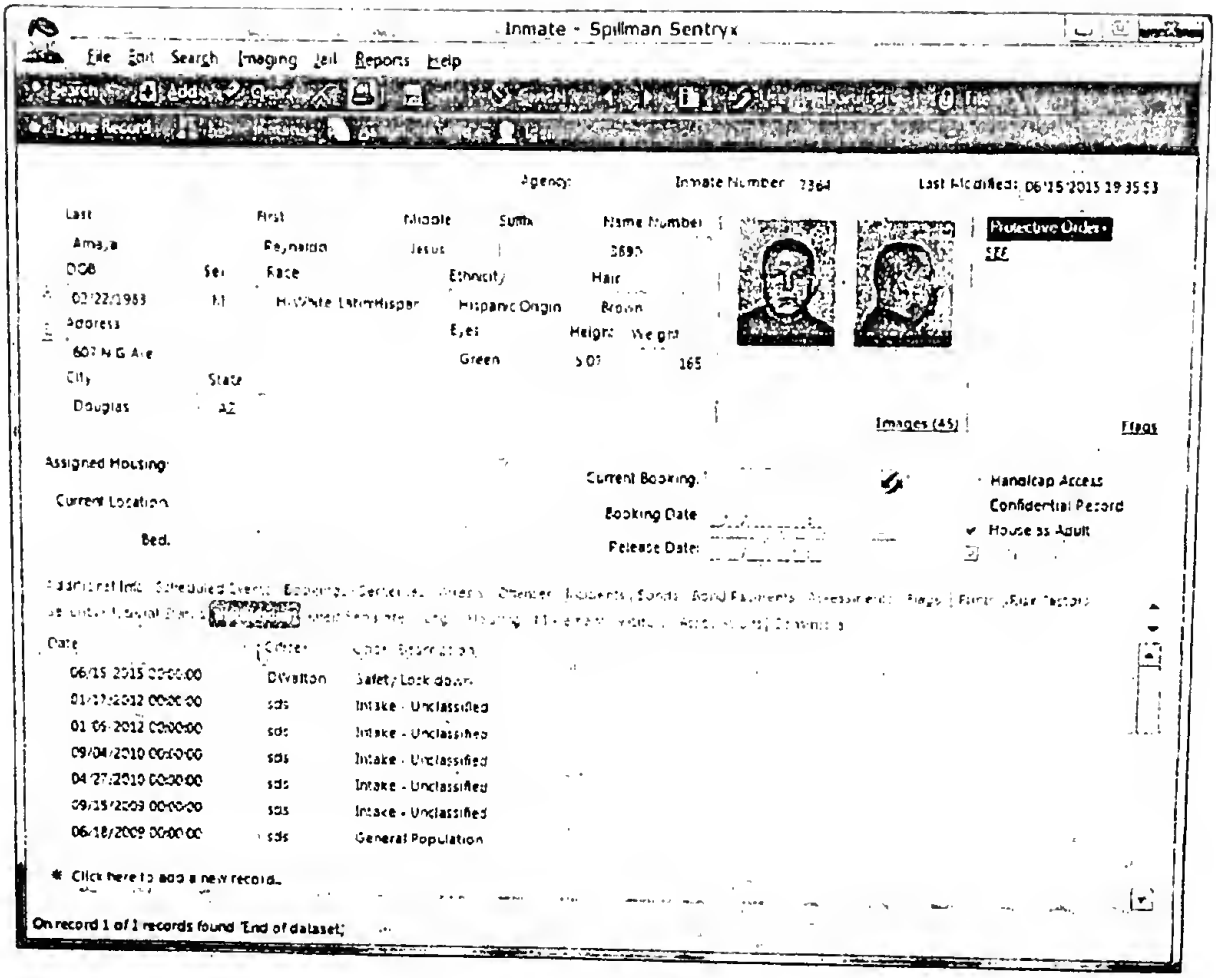
On record 1 of 1 records found (End of dataset)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Agency:
Inmate Number: 7364
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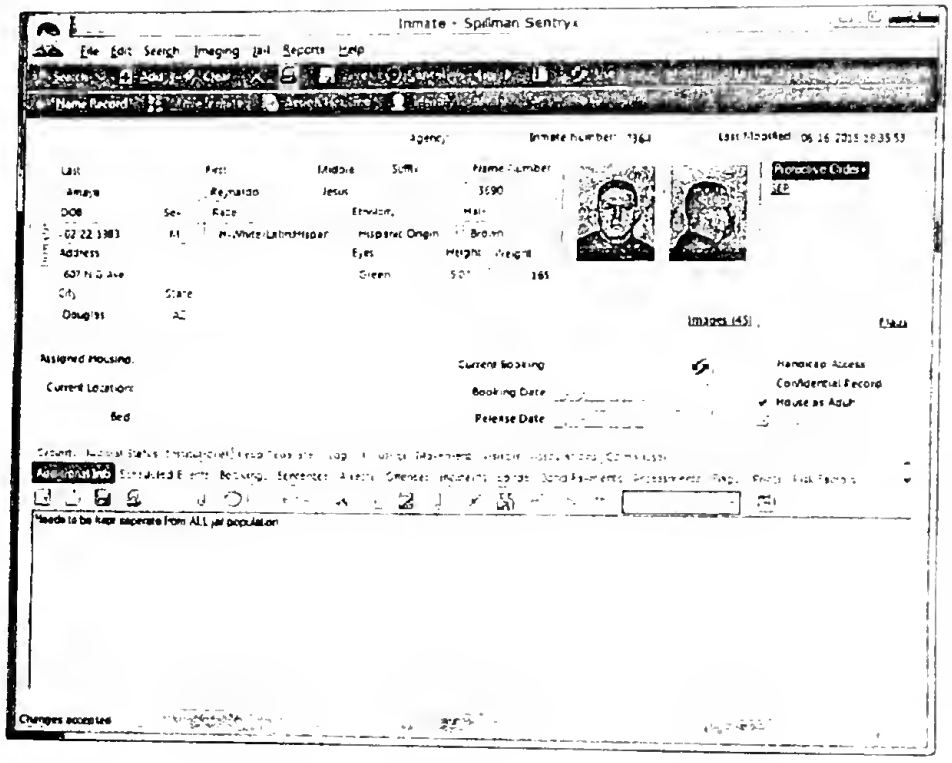
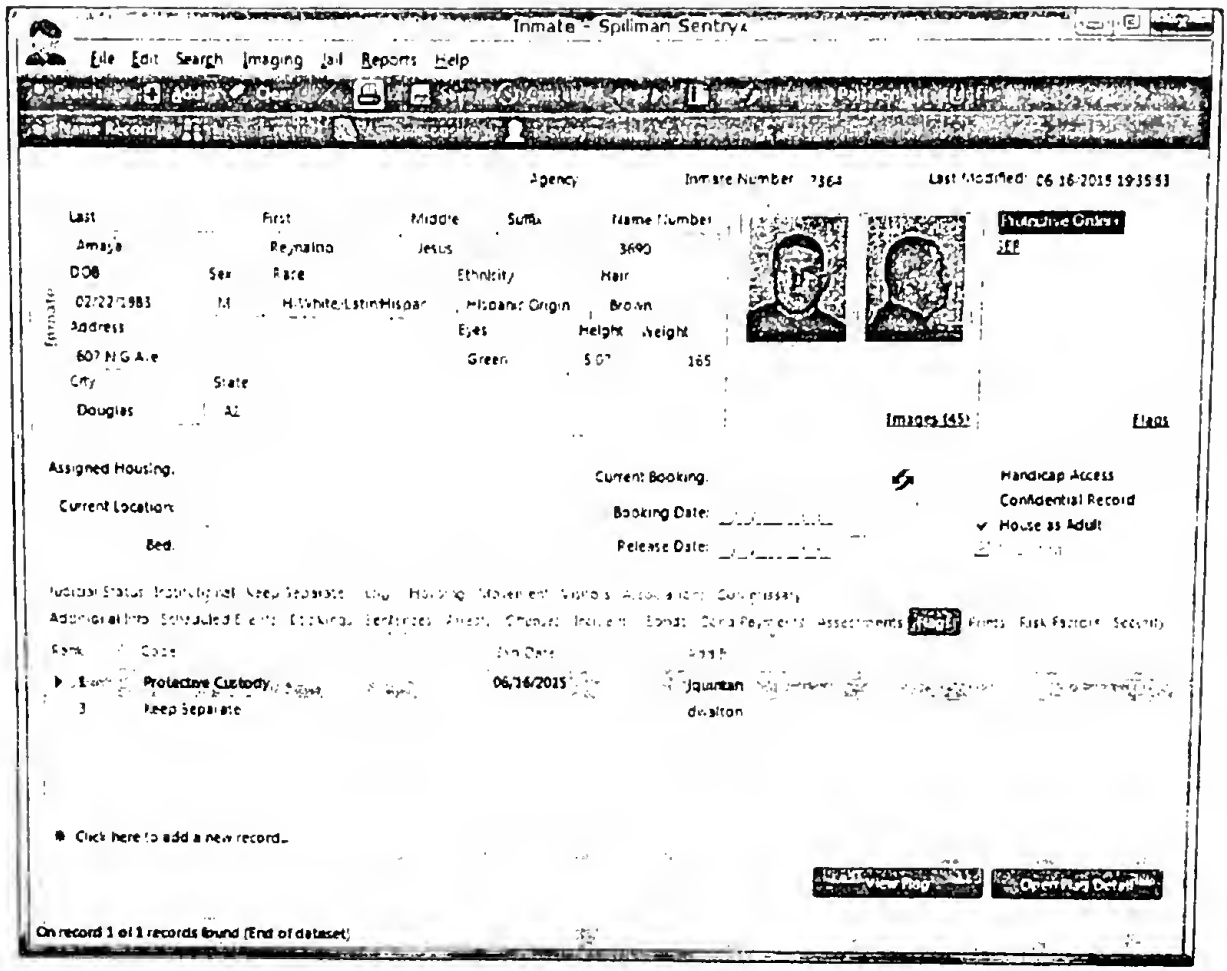
Sex
M
Race
H=White Latin=Hispan
Ethnicity
Hispanic Origin
Hair
Brown
Eyes
Green
Height
5'07
Weight
165
Address
607 N G Ave
City
Douglas
State
AZ
Protective Order
SEX
Images (45)
Flags
Assigned Housing:
Current Location:
Bed:
Current Booking:
Booking Date:
Release Date:
Handicap Access
Confidential Record
House as Adult
Date
Center
Unit
06/15/2015 00:00:00
Division
Safety Lock down
01/27/2012 00:00:00
sds
Intake - Unclassified
01/05/2012 00:00:00
sds
Intake - Unclassified
09/04/2010 00:00:00
sds
Intake - Unclassified
04/27/2010 00:00:00
sds
Intake - Unclassified
09/15/2009 00:00:00
sds
Intake - Unclassified
06/18/2009 00:00:00
sds
General Population
Click here to add a new record.
On record 1 of 1 records found 'End of dataset'


Inmate - Spillman Sentry
File Edit Search Imaging Jail Reports Help
Name Record
Agency
Inmate Number
Last Modified
Last
First
Middle
Suffix
Name Number
Amaya
Reynaldo
Jesus
3690
DOB
Sex
Race
Ethnicity
Hair
02 22 1983
M
W-White/Latino/Hispan
Hispanic Origin
Brown
Address
Eyes
Height
Weight
607 N G Ave
Green
5'0"
165
City
State
Douglas
AZ
Protective Orders
SEP
Images (45)
Assigned Housing
Current Location
Bed
Current Booking
Booking Date
Release Date
Handicap Access
Confidential Record
House as Adult
Assigned Info
Scheduled Events
Booking
Sentences
Alerts
Offenses
Incidents
Charges
Bond Payments
Bond Agreements
Diagnosis
Photos
Risk Factors
Needs to be kept seperate from ALL jail population
Changes accepted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File Edit Search Imaging Jail Reports Help
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Inmate Number 7364
Last Modified: 06/16/2015 19:35:53
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Amaya
First
Reynaldo
Middle
Jesus
Suffix
Name Number
3690
DOB
02/22/1983
Sex
M
Race
H:White;Latin/Hispar
Ethnicity
Hispanic Origin
Hair
Brown
Address
607 N G Ave
Eyes
Green
Height
5 07
Weight
165
City
Douglas
State
AZ
Protective Custody
Images (45)
Flags
Assigned Housing:
Current Location:
Bed:
Current Booking:
Booking Date:
Release Date:
Handicap Access
Confidential Record
House as Adult
Rank
Code
Beg Date
Protective Custody
Keep Separate
06/16/2015
jquintan
dwalton
Click here to add a new record...
On record 1 of 1 records found (End of dataset)

06/17/2015 Cochise County Jail Bisbee
10:49:15 Risk Assessment
Booking Number: Confined
Name Number: 3690 Reynaldo Amaya
Assessment Date: Monday, 06/15/2015 09:26 AM **Who:** JQuintana
Risk Class: MED
Final Score: 6

Classification:

From	To	Description
-5	5	Minimum Security
6	10	Medium Security
11	99	Maximum

Risk Assessment Questions:

Question: Severity of Current Charges
Answer: Moderate
Notes: AGG DV - FEL DV AGG ASSLT- FEL DV USE OF ELECT DEV TO HARRASS- FEL (POS PAROLE VIOL) ADC

Question: Escape History
Answer: No Attempts
Notes:

Question: Criminal Offense History
Answer: Moderate
Notes: AGG DV- FEL ADC# 270236

Question: Detainers or Warrants
Answer: No pending Court actions:
Notes:

Question: Age Stability Factor
Answer: 26 Yrs old or older
Notes: AGE 32

Question: Employment Stabiliy Factor
Answer: Not employeed
Notes:

Question: Education Stability Factor
Answer: Not attending School
Notes:

Question: Residential Stability Factor
Answer: Lived at same addrss for less than a year
Notes:

Question: Institutional Disciplinary History
Answer: None or minor with no segregation time
Notes:

Question: Prior Convictions
Answer: Two or more prior charges/convictions
Notes: DV Threats and Stalking - fels priors include a) numerous DV's - mis b) Agg asslt - fel c) Rest arrst - fel d) Kidnap - fel e) numerous Traff citatns - mis

Question: Alcohol or Drug Abuse
Answer: no social, econoic, or legal problems
Notes:

Question: Special Management Concerns
Answer: Yes
Notes:

Question: Is here Psychological Impairement
Answer: No
Notes:

Question: Is there Mental Deficiency
Answer: No
Notes:

Question: Is there Medical Problems
Answer: No
Notes:

Question: Is there Physical Impairment
Answer: No

Notes:

Question: Is here Substance Abuse Problem
Answer: No
Notes:

Question: Is the inmate a suicide Risk
Answer: No
Notes:

Question: Protective Custody needed
Answer: Yes
Notes: I/M REQUEST DUE TO ISSUES AT ADC @@ FROM ALL POPULATION, OK FOR ND POD

Question: Is inmate Serious Violence Threat
Answer: No
Notes:

Question: Escape Risk
Answer: No
Notes:

Question: Known Management Problems
Answer: No
Notes:

Question: Suspected Management Problem
Answer: No
Notes:

Question: Suspected drug Trafficker
Answer: No
Notes:

Question: Are you an Active Gang Member
Answer: No
Notes:

EXHIBIT 3

Policy Number: D.034	Effective Date: 6/18/12	COCHISE COUNTY SHERIFF'S OFFICE DETENTION DIVISION
Topic: PROXIPEN GUARD TOUR SYSTEM		
Authorization:  Kenneth E. Bradshaw, Jail Commander	Supersedes: D950323.034 PROXIPEN GUARD TOUR SYSTEM	STANDARD OPERATING PROCEDURES

1.0.0 POLICY

1.1.0 The ProxiPen Guard Tour System shall be used to document scheduled Security Checks conducted by detention staff and supervisors in the following areas:

1.1.1 Central A; B

1.1.2 North A; B; C; D

1.1.3 South A; B; C; D; E

1.1.4 Special Handling

1.1.5 Perimeter Fence

1.1.6 Laundry Room

1.1.7 Kitchen

1.2.0 Scheduled Security Checks will be conducted at the following times:

1.2.1 Staff will conduct scheduled Security Checks every **30 minutes** in all inmate housing areas; when conducting a security check of a housing area the officer must visually inspect every individual cell.

1.2.2 **Supervisors** will conduct one scheduled Security Check in all inmate housing areas during their shift.

1.2.3 Perimeter fence, 3 times per shift.

1.2.4 Kitchen and Laundry Room, every **30 minutes**.

2.0.0 PROCEDURES

2.1.0 The ProxiPen Guard Tour System consists of a tag reader (Wand) that reads RFID (Radio Frequency Identification) tags that are permanently mounted at points to be visited, requiring the

EXHIBIT 4

THE COUNTRY LAWYER, P.C.
741 East Fry Blvd.
Sierra Vista, Arizona 85635
(520) 459-6400
FAX: (520) 459-2540

PERRY HICKS
Attorney for Plaintiff
State Bar No. 007695

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF COCHISE

RAMONA AMAYA, mother of deceased, Reynaldo Amaya Plaintiff, vs. COCHISE COUNTY SHERIFF MARK DANNELS, Defendant.	NO. CV201600305 **AFFIDAVIT OF LINDSAY M. HAYES** DIV. FOUR

STATE OF MASSACHUSETTS)
COUNTY OF BRISTOL)

LINDSAY M. HAYES, being first duly sworn, upon his oath deposes and says:

1. I am a project director of the National Center on Institutions and Alternatives, with an office in Mansfield, Massachusetts. I am a nationally-recognized expert in the field of suicide prevention in correctional facilities. I have served as project director for the only five national U.S. Justice Department-funded studies conducted of jail, prison, and juvenile suicide. I have authored over 100 publications addressing the topic of suicide prevention in jail, prison, and juvenile facilities. Since 1983 I have served as a consultant in providing staff training and program assessment/development services in the area of suicide prevention in correctional facilities to various county and state jurisdictions throughout the

country. I have served as the suicide prevention consultant to the Special Litigation Section of the U.S. Justice Department's Civil Right's Division and to the Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security in their investigations of conditions of confinement in various correctional facilities, as well as serving as consultant to several state departments of correction and state juvenile correctional agencies in the area of suicide prevention. I have been appointed as a federal court monitor (and expert to special masters/monitors) in the monitoring of suicide prevention practices in several adult and juvenile correctional systems under court jurisdiction. I have reviewed/and or examined over 3,500 cases of suicide in jail, prison and juvenile facilities throughout the country during the past 37 years, have served as an expert witness/consultant in over 400 litigation cases involving suicide in correctional facilities, and have been qualified as an expert in both federal and state courts throughout the country. I am a past recipient of the National Commission on Correctional Health Care's Award of Excellence (2001) for outstanding contribution in the field of suicide prevention in correctional facilities.

2. I have reviewed the documents in the case of the suicide of Reynaldo Amaya which are listed at pages 3 and 4 of the Assessment attached hereto as Attachment A.

3. The attached Assessment represents my opinion, to a reasonable degree of professional certainty, of the circumstances surrounding the suicide of Reynaldo Amaya.

4. I have reviewed the CCTV surveillance recording of North D Pod of the Cochise County Jail on June 16, 2015. That recording indicates that detention officers often simply glanced at, and did not stop and look directly into, Mr. Amaya's cell during the more than two-hour period from approximately 2:04 to 4:42 PM. As such, it is dubious whether officers actually saw Mr. Amaya during all of these 30-minute cell checks.

5. As elaborated in the attached Assessment, it is my opinion that the decision of Sergeant Figueroa not to place Mr. Amaya on suicide precautions as requested by other Cochise County Sheriff's Office personnel, as well as the failure to refer him to a mental health professional, was in violation of the jail's suicide prevention policy, contrary to the standard of care, and a proximate cause of Mr. Amaya's suicide the following day.

6. It is my opinion that observation of any suicidal inmates at 30-minute intervals is grossly inadequate, well below the standard of care, and contrary to national correctional standards that require observation between constant and continuous through staggered intervals that do not exceed fifteen minutes. National standards further require suicidal inmates to be housed in cells without protrusions of any kind that would enable the inmate to hang himself/herself.

L M. Hayes

LINDSAY M. HAYES

SUBSCRIBED AND SWORN to before me, the undersigned notary, this 7th day of November, 2018, by LINDSAY M. HAYES.

Notary Public

My Commission Expires: 8/22/25

ATTACHMENT A TO EXHIBIT 4

ASSESSMENT OF *AMAYA v. COCHISE COUNTY, ET. AL.*

Introduction

Detailed below is this writer's assessment of the above captioned case. Such assessment is based upon review of documents supplied to date and identified below. This writer previously submitted a preliminary assessment on this case dated April 21, 2018. This updated assessment is based upon additional documents received and reviewed following that initial assessment; specifically, several deposition transcripts and a defense expert's report. This writer reserves the option of again amending and/or enlarging upon this assessment if any subsequent documents become available.

By way of background, this writer is a project director of the National Center on Institutions and Alternatives, with an office in Mansfield, Massachusetts. A nationally recognized expert in the field of suicide prevention in correctional facilities, this writer has served as project director for the only five national U.S. Justice Department-funded studies conducted of jail, prison, and juvenile suicide. This writer previously served as editor and project director for the *Jail Suicide/Mental Health Update* newsletter, a quarterly publication devoted to research, training and prevention that was funded by the U.S. Justice Department from 1986 through 2009. This writer has authored over 100 publications in the area of suicide prevention in jail, prison, and juvenile facilities. These publications are listed in the curriculum vitae attached as Exhibit 1.

In addition, since 1983, this writer has served as a consultant in providing staff training and program assessment/development services in the area of suicide prevention in

ATTACHMENT A TO EXHIBIT 4

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In addition, since 1983, this writer has served as a consultant in providing staff training and program assessment/development services in the area of suicide prevention in

correctional facilities to various county and state jurisdictions throughout the country. This writer has also served as the suicide prevention consultant to the Special Litigation Section of the U.S. Justice Department's Civil Rights Division and Office of Civil Rights and Civil Liberties of the U.S. Department of Homeland Security in their investigations of conditions of confinement in various correctional facilities; as well as serves as a consultant to several state departments of correction and state juvenile correctional agencies in the area of suicide prevention.

Further, this writer has been appointed as a federal court monitor (and expert to special masters/monitors) in the monitoring of suicide prevention practices in several adult and juvenile correctional systems under court jurisdiction. Finally, this writer has served as an expert witness/consultant in over 400 litigation cases involving suicide in correctional facilities, and has been qualified as an expert in both federal and state courts throughout the country.

This writer was a past recipient of the National Commission on Correctional Health Care's Award of Excellence (2001) for outstanding contribution in the field of suicide prevention in correctional facilities. This writer's work has been cited in the suicide prevention sections of various state and national correctional health care standards, and training curricula has been utilized by hundreds of correctional agencies throughout the country.

Finally, as a result of research, technical assistance, and consultant work in the area of suicide prevention in correctional facilities, this writer has reviewed and/or examined over 3,500 cases of suicide in jail, prison, and juvenile facilities throughout the country during the past 37 years.

Documents Reviewed

The following documents were reviewed in preparation of this assessment. They include:

- Complaint;
- Defendant's Initial Disclosure Statement; Defendant's Response to Plaintiff's Non-Uniform Interrogatories; and Defendant's Response to Plaintiff's Request for Production;
- Various arrest records for Reynaldo Amaya by the Cochise County Sheriff's Office on June 14, 2015, including the officer statement of probable cause by Deputy Philip Hogan;
- Various jail records for Mr. Amaya in the Cochise County Jail from June 14, 2015 through June 16, 2015;
- Various records of Mr. Amaya's prior confinement in the Cochise County Jail;
- Autopsy Report;
- Investigative investigation Report of Mr. Amaya's Suicide by Cochise County Sheriff's Office Lieutenant Ariel Monge;
- Various photographs of Mr. Amaya's cell in the Cochise County Jail following his suicide;
- DVD closed-circuit television surveillance of Mr. Amaya's housing unit on June 16, 2015;
- Various incident reports and recorded interviews of Cochise County Jail staff and inmates regarding Mr. Amaya's suicide;
- Cochise County Jail Service Journal (housing logs);

- Various Cochise County Sheriff's Office policies and procedures, including the Proxipen Guard Tour System; Suicide Prevention; Classification Process: Booking, Intake, Identification and Consular Notifications; Mental Health/Medical Referrals; and North D Pod, Special Handling, and Administrative Segregation;

- Deposition transcripts, and accompanying exhibits, for Benjamin Acuna, Ramona Amaya, Roger Clark, Fernando Figueroa, and Philip Hogan; and

- Defense expert report of Sean Stewart dated June 19, 2018.

Finally, this writer has reviewed the following nationally recognized correctional standards: American Correctional Association (ACA)'s *Performance-Based Standards for Adult Local Detention Facilities*, 4th Edition (2004); National Commission on Correctional Health Care (NCCHC)'s *Standards for Health Services in Jails*, 9th Edition (2014); and the "Suicide Prevention and Intervention Standard" from the U.S. Department of Homeland Security's *Operations Manual ICE Performance-Based National Detention Standards* (2011).[1]

Case Analysis

This writer was asked by plaintiff's counsel to examine all pertinent documents available in this case to date, and give a preliminary opinion as to whether, through policy and practice, the actions and/or inactions by Cochise County and its Cochise County Jail staff were either contrary to, or inconsistent with, both jail standards and standard correctional

[1]See American Correctional Association (2004), *Performance-Based Standards for Adult Local Detention Facilities*, 4th Edition, Laurel, MD: Author; National Commission on Correctional Health Care (2014), *Standards for Health Services in Jails*, 9th Edition, Chicago, IL: Author; and U.S. Department of Homeland Security (2011), Immigration and Customs Enforcement, *Operations Manual ICE Performance-Based National Detention Standards*, Washington, DC: Author.

practice, and were related to Reynaldo Amaya's suicide in the Cochise County Jail on June 16, 2015.

The methodology this writer utilizes to review a suicide is to review and analyze documentation, determine the facts upon which to rely and compare the actions of officials and their staff to the applicable state and/or national standards, as well as well-established reasonable practices in the correctional facility setting, in this case, a county jail facility. This writer then bases his professional opinions on this comparison, as well as my education, training and experience, including conducting the only five national studies on inmate suicide for the US Justice Department, developing training curricula on suicide detection and prevention in jail and prison facilities, developing and/or revising suicide prevention policies, and acting as a federal court monitor in jail, prison, and juvenile facilities throughout the country.

Reynaldo Amaya

According to available records, Reynaldo Amaya, 32-years-old, was arrested by Cochise County Sheriff's Office (CCSO) deputies for aggravated domestic violence and aggravated domestic harassment on his former girlfriend during the late evening of June 14, 2015. Mr. Amaya was initially transported to the CCSO substation in Douglas. According to one of the arresting officers (see Deputy Philip Hogan's Officer Statement of Probable Cause), Mr. Amaya began to engage in self-injurious behavior both at the Douglas substation and in the patrol car, and "I went in to speak with Amaya and he began to hit his head with the handcuffs and stated he would start hitting his head against the

walls. He was detained in the handcuffs behind his back and secured in my patrol unit where he began to hit his head on the metal prisoner compartment. Amaya refused to talk to me and was later transported to the CCSO Jail in Bisbee and booked for the listed charges."

In addition, Deputy Hogan's arrest report further stated that Mr. Amaya stated "he did not give a f__k he was still going back to prison. He continued to beat his head against my patrol unit he was told to knock it off and he refused. Amaya stated he would f__k himself up more he did this shit on purpose. Amaya refused to talk to me. One Douglas PD Office was contacted to assist me in watching Amaya so I could complete the jail paperwork for booking."

Further, another arresting officer (Deputy Roger Clark) called the Cochise County Jail in Bisbee at approximately 12:56am on June 15 and informed Detention Officer Benjamin Acuna that "a deputy was on his way with one that was banging his head; please keep an extra eye on him or maybe even suicide watch." When Officer Acuna asked Deputy Clark why Mr. Amaya needed additional observation, the deputy responded that "someone banging his head that hard needs to be watched closely." More specifically, a cell phone text from Deputies Clark to Hogan stated the following: "I advised detention of his actions and requested someone standing by for you and suicide watch for him."

Upon arrival at the Cochise County Jail in the early morning of June 15, 2015, custody of Mr. Amaya was transferred from Deputy Hogan to several detention staff,

including Detention Officer Acuna and Sergeant Fernando Figueroa. Officer Acuna processed the inmate and completed the Risk Assessment and Initial Medical Assessment forms on Mr. Amaya. The inmate apparently answered "no" to all Initial Medical Assessment questions. Officer Acuna did *not* complete the 16-item Initial Inmate Assessment on Mr. Amaya as required. According to Sergeant Figueroa, he briefly conversed with Mr. Amaya and the inmate denied any further suicidal and self-injurious behavior. There was no written documentation from the available records to indicate that either Sergeant Figueroa or Officer Acuna conversed with Deputy Hogan regarding the inmate's self-injurious behavior during the arrest and transport to the Cochise County Jail, instead relying exclusively on Mr. Amaya's denial of self-injurious behavior.

Although initially housed in general population, Mr. Amaya was subsequently rehoused in administrative segregation on North D Pod of the facility because he had reported during a classification interview later that morning (June 15) he needed protective custody status because of issues during a recent Arizona Department of Corrections incarceration, and his fear that a "hit" had been placed on him.

Mr. Amaya later received Medical Intake Screening by a nurse on June 15, reporting several medical issues, but denied any current or prior suicidal ideation. He did report that an uncle had committed suicide in 1993. The inmate did not have any other significant interaction with medical staff, nor was he ever referred to mental health personnel for further assessment.

Further, it was noteworthy that documentation indicated that Mr. Amaya had previously been confined in the Cochise County Jail three years earlier on January 18, 2012 and was placed on suicide watch because he "tried to hurt himself while in custody at DG POE (Douglas Port of Entry) and SW-30 (special watch at 30-minute intervals) has been implemented."

As indicated by the closed-circuit television (CCTV) surveillance of North D Pod on June 16, 2015, Mr. Amaya last walked into his cell (No. 5) at approximately 2:04pm. Inmates housed in this segregation unit were required to be observed by officers at 30-minute intervals. The CCTV surveillance recording indicated that officers conducting rounds in the unit often simply glanced at, and did not stop and look directly into, Mr. Amaya's cell. At approximately 4:39pm, an officer opened the food port of Mr. Amaya's cell, but did not look into the cell. Approximately two minutes later at 4:41pm, the same officer placed a meal tray in the food port of the inmate's cell, but did not look into the cell. Returning approximately a minute later at 4:42pm and realizing that Mr. Amaya had not taken his tray, the officer looked directly into the cell and appeared to be trying to locate the inmate inside the cell. The officer appeared to casually ask for assistance and then departed of the tier. At approximately 4:44pm, another officer arrived, looked into Mr. Amaya's cell and then opened the cell door to find the inmate hanging from a ventilation grate by a sheet. An emergency was called, other detention officers responded, and cardiopulmonary resuscitation (CPR) was initiated. A jail nurse subsequently arrived and continued to assist with CPR until emergency medical services personnel arrived and

continued life-saving measures. Mr. Amaya was transported to a local hospital and subsequently pronounced dead.

Opinions

Based upon review of the case file materials and above summary, this writer offers the following opinions. Such opinions are based upon a reasonable degree of professional certainty. *First*, Reynaldo Amaya was observed to be engaging in self-injurious behavior during arrest and transportation by CCSO Deputy Philip Hogan. This information was communicated to Cochise County Jail staff, specifically Detention Officer Benjamin Acuna and Sergeant Fernando Figueroa, as well the request to place Mr. Amaya on suicide watch. Despite having knowledge of his self-injurious behavior and request for suicide watch, Officer Acuna and Sergeant Figueroa failed to communicate such information to either medical or mental health personnel. These inactions were not only in violation of the agency's suicide prevention policy, but contrary to the standard of care, and a proximate cause of Mr. Amaya's suicide the following day. In addition, Officer Acuna failed to complete the 16-item Initial Inmate Assessment on Mr. Amaya as required. *Second*, inmates housed in segregation within the Cochise County Jail were required to be observed by detention officers at 30-minute intervals. CCTV surveillance recording of North D Pod on June 16, 2015 indicated that detention officers often simply glanced at, and did not stop and look directly into, Mr. Amaya's cell during the more than two-hour period of approximately 2:04pm and 4:42pm. As such, it was dubious whether officers actually saw the inmate during all of these 30-minute cell checks. *Third*, the CCSO's suicide prevention policy was inadequate and contrary to national correctional standards. *Fourth*,

although suicide prevention training materials and staff compliance with such training were not available for review and any final opinion regarding the quality of any such training by the CCSO would be deferred at this time, any training that allowed detention personnel, including Sergeant Figueroa, to make a decision that an inmate engaging in self-injurious behavior, as well as having a prior history of suicide watch within the jail, did not warrant notification to mental health personnel for further assessment would be grossly inadequate, contrary to the standard of care, and reflect inadequate training. The basis for these opinions is offered below.

1) **Reynaldo Amaya's Self-Injurious Behavior Was Known to Cochise County Jail Staff**

Reynaldo Amaya was observed to be engaging in self-injurious behavior during arrest and transportation by CCSO Deputy Philip Hogan. This information was communicated to Cochise County Jail staff, specifically Detention Officer Benjamin Acuna and Sergeant Fernando Figueroa, as well the request to place Mr. Amaya on suicide watch. Despite having knowledge of his self-injurious behavior and request for suicide watch, Officer Acuna and Sergeant Figueroa failed to communicate such information to either medical or mental health personnel. These inactions were not only in violation of the agency's suicide prevention policy, but contrary to the standard of care, and a proximate cause of Mr. Amaya's suicide the following day. In addition, Officer Acuna failed to complete the 16-item Initial Inmate Assessment on Mr. Amaya as required.

CCSO Deputy Roger Clark called the Cochise County Jail in Bisbee at approximately 12:56am on June 15 and informed Detention Officer Benjamin Acuna that

a deputy (Philip Hogan) "was on his way with one that was banging his head; please keep an extra eye on him or maybe even ***suicide watch***." When Officer Acuna asked Deputy Clark why Mr. Amaya needed additional observation, the deputy responded that "someone banging his head that hard needs to be ***watched closely***." More specifically, a cell phone text between Deputies Clark and Hogan stated the following: "***I advised detention of his actions and requested someone standing by for you and suicide watch for him.***"

During deposition testimony in this case, Deputy Clark testified (at pages 21-22) that during his telephone conversation with Detention Officer Acuna, "I recall telling him that Deputy Hogan was in route to the detention center with an arrested subject. I advised him to place the subject on watch." When asked if the recommendation was for a "suicide watch," Deputy Clark testified "I believe more specifically suicide watch is what my wording was." Detention Officer Acuna testified during his deposition (at pages 9-10) that Deputy Clark told him Mr. Amaya "needed to be watched particularly; that he was hitting his head against the wall in the holding cell at the Douglas substation; and that he had - that he may - that we may need extra officers inside the sally port area due to being combative coming in." When then asked whether Deputy Clark had used the term "suicide watch," Officer Acuna stated (at page 10): "I'm not actually even sure. I don't even know if that's a possibility. I mean, I sure - sure I would remember if he did specifically say he needed to be on suicide watch. All I remember is saying that he needed to be watched."

Regardless of whether Officer Acuna heard Deputy Clark use the phrase "suicide watch" or "needed to be watched" in reference to Mr. Amaya's self-injurious behavior, any

reasonable individual would interpret the concern in a similar manner, i.e., that the inmate was at risk of suicide, needed to be placed on an observation status, and referred to a mental health clinician (Behavioral Health Coordinator according to CCSO policy) for further assessment. When the CCSO Licutenant (Ariel Monge) conducting the investigation of Mr. Amaya's suicide asked Officer Aeuna why he did not refer Mr. Amaya to the Behavioral Health Coordinator, the response was: "Officer Acuna said he just didn't do it." Of note, Lieutenant Monge's investigation also found that Officer Acuna did not have a reasonable explanation for failing to complete the 16-item Initial Inmate Assessment on Mr. Amaya as required.

Any ambiguity regarding whether Deputy Clark instructed Officer Acuna to place Mr. Amaya on "suicide watch" or "needed to be watched" was cleared up during the deposition testimony of Sergeant Fernando Figueroa. *Sergeant Figueroa acknowledged during his deposition (at pages 27-28) that the Cochise County Jail control officer notified him that Deputy Clark had recommended that Mr. Amaya be placed on* ***suicide watch.***

Despite the communication of this specific information regarding Mr. Amaya's self-injurious behavior by Deputy Clark, and the need to place the inmate on suicide watch, as well as written documentation of such behavior in both Deputy Hogan's Officer Statement of Probable Cause and the Arrest Report, Officer Acuna and Sergeant Figueroa chose to ignore it and subsequently placed the inmate in a segregation unit because of Mr. Amaya's concern that he might be assaulted by other inmates. Sergeant Figueroa was later interviewed by Licutenant Monge and stated that Mr. Amaya was cooperative during the

booking process and promised "that he was not trying to hurt himself anymore and would not hurt himself while he was here in jail. His demeanor was not of the person who was trying to hurt himself in my observation." Sergeant Figueroa reiterated this position during his deposition testimony by stating that Mr. Amaya "even started smiling" (at page 35). He continued to justify his decision by stating during his deposition (at page 47) that "I made that decision 'cause I assessed him, and I was - spoke to him, and he didn't show any signs of that he was going to hurt himself in my opinion. So it didn't deem it necessary to put him on a watch..."

Sergeant Figueroa also testified that his decision was made, in part, by the fact that he claimed to know Mr. Amaya very well, but that "I don't recall" (at page 38) the inmate had been placed on suicide during a previous confinement in the Cochise County Jail in January 2012. Despite the commonly known fact that prior risk of suicide may be an indicator of current risk of suicide based upon research, including national studies on inmate suicide conducted by this writer finding that 34 percent of inmates who committed suicide had prior histories of a suicidal behavior (including placement on suicide precautions during confinement).[2] Sergeant Figueroa testified (at pages 38-39) that he still would *not* have placed Mr. Amaya on suicide watch even if he remembered that the inmate had been previously placed on suicide watch.

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[2]See, for example, Hayes, L.M., "National Study of Jail Suicides: 20 Years Later," *Journal of Correctional Health Care*, 18 (3), 2012; National Study of Jail Suicides: 20 Years Later, Washington, DC: National Institute of Corrections, U.S. Department of Justice, April 2010. In addition, He et al. (2001) found a strong association with completed suicides and prior suicide attempts during confinement. The researchers reviewed Texas prison suicides occurring over a 12-month period and found that over 64% of inmates committing suicide had made at least one prior suicide attempt while in prison (see He XY, Felthous AR, Holzer CE, et al: "Factors in Prison Suicide: One Year of Study in Texas," *Journal of Forensic Sciences* 46: 896-901, 2001).

Of course, Sergeant Figueroa was not a mental health professional and, therefore, not qualified conduct such an "assessment." His decision was also contrary to the CCSO's suicide prevention policy which stated that: "If the inmate tries to inflict self-injury, the detention officer will request immediate assistance from all available staff to prevent further self-injury." In addition, the suicide prevention policy required that "Officers in doubt will have the person seen by the Behavior Health Coordinator at the time of booking if possible, or, in the absence of the BHC, to place the inmate on an appropriate observation and will refer the inmate to the Behavioral Health Coordinator through a Mental Health/Medical Referral Form."

Sergeant Figueroa's decision not to place Mr. Amaya on suicide watch as requested by other CCSO deputies, as well as his failure to refer the inmate to a mental health professional, was not only in violation of the agency's suicide prevention policy, but contrary to the standard of care and a proximate cause of the inmate's suicide the following day. The sergeant's actions also defied common sense because if an inmate's simple denial that they were suicidal or promised not to continue to engage in self-injurious behavior, or "even smiled," were the simple criteria utilized to assess suicide risk, than it would be unnecessary to ask any other questions during the intake screening process, nor would a jail system need a mental health clinician to make an assessment because any jail personnel could listen to an inmate deny they were suicidal, or see them smile, and assume they were not. In sum, Sergeant Figueroa's decision to place himself in the position of a mental health clinician proved to be fatal in Mr. Amaya's case.

In addition, the suicide prevention policy required that the booking officer (Officer Acuna in this case) complete an Initial Inmate Assessment form. The screening form contained 16 lines of inquiry regarding suicide risk, mental illness, and behavior, as well as inquiry directly to the arresting officer: "*Does the arresting officer believe the inmate is suicidal*?" And affirmative response to this question required referral to a mental health clinician (i.e., the Behavioral Health Coordinator). Officer Acuna failed to complete the Initial Inmate Assessment form in Mr. Amaya's case. If the form had been completed as required, and an affirmative response recorded to that question, Mr. Amaya probably would have been referred to a mental health clinician.

Finally, as noted above, there was information available that indicated Mr. Amaya had previously been confined in the Cochise County Jail three years earlier and was placed on suicide watch on January 18, 2012. Documentation indicated that several detention personnel who interacted with Mr. Amaya on June 15 and 16, 2015, including Sergeant Figueroa, also interacted with him when he was previously on suicide watch in January 2012.

2) <u>Failure of Cochise County Jail Personnel to Adequately Observe Mr. Amaya</u>

Inmates housed in segregation within the Cochise County Jail were required to be observed by detention officers at 30-minute intervals. CCTV surveillance recording of North D Pod for June 16, 2015 indicated that detention officers often simply glanced at,

and did not stop and look directly into, Mr. Amaya's cell during the more than two-hour period of approximately 2:04pm and 4:42pm. The CCTV surveillance recording indicated the following:

> 2:04pm - Mr. Amaya escorted to his cell and conversed with an officer for approximately one minute;
>
> 2:27pm - an officer glanced at, but did not stop and look directly into, the cell;
>
> 3:00pm - an officer glanced at, but did not stop and look directly into, the cell;
>
> 3:23pm - an officer stopped and conversed with Mr. Amaya at cell front;
>
> 3:53pm - an officer glanced at, but did not stop and look directly into, the cell;
>
> 4:20pm - an officer glanced at, but did not stop and look directly into, the cell;
>
> 4:21pm - an officer stops and looks directly into the cell;
>
> 4:39pm - an officer unlocks the food port on the cell door but does not look into the cell;
>
> 4:41pm - an officer places a meal tray on the food port but does not look into the cell;
>
> 4:42pm - an officer notices the meal tray remained on the food port and looks into the cell in an apparent attempt to locate the inmate. The officer appeared to casually ask for assistance and then depart the tier; and
>
> 4:44pm – another officer looked directly into the cell and located Mr. Amaya's body in the front right corner. The cell door was open and an emergency response was activated.

As observed by the CCTV surveillance recording, it was dubious whether officers actually saw the inmate during all of these 30-minute cell checks.

3) Inadequate Suicide Prevention Policies and Procedures

The CCSO's suicide prevention policy was inadequate and contrary to national correctional standards. A sound written suicide prevention policy is a prerequisite for running a correctional facility of any size. The importance of written policy in suicide prevention is clearly stated in the American Correctional Association (ACA)'s *Performance-Based Standards for Adult Local Detention Facilities* (4-ADLF-4C-32): "A suicide-prevention program is approved by the health authority and reviewed by the facility or program administrator. It includes specific procedures for handling intake, screening, identifying, and supervising of a suicide-prone inmate and is signed and reviewed annually," and recommends annual training in the "signs of suicide risk" and "suicide precautions."[3] In addition, and as outlined below, the National Commission on Correctional Health Care (NCCHC)'s *Standards for Health Service in Jails* (J-G-05) requires each jail to have a written suicide prevention plan that includes the following components:

> **1) Training.** All staff members who work with inmates are trained to recognize verbal and behavioral cues that indicate potential suicide, and how to respond appropriately. Initial and at least biennial training are provided, although annual training is highly recommended.
>
> **2) Identification.** The receiving screening form contains observation and interview items related to the inmate's potential suicide risk. If a staff member identifies someone who is potentially suicidal, the inmate is placed on suicide precautions and is referred immediately to mental health staff.
>
> **3) Referral.** There are procedures for referring potentially suicidal inmates and those who have attempted suicide to mental health care providers or facilities. The procedures specify a time frame for response to the referral.
>
> **4) Evaluation**. An evaluation, conducted by a qualified mental health professional, designates the individual's level of suicide risk, level of

[3]American Correctional Association (2004), *Performance-Based Standards for Adult Local Detention Facilities* (4th Edition), Lanham, MD: Author.

supervision needed, and need for transfer to an inpatient mental health facility or program. Patients are reassessed regularly to identify any changes in condition indicating a need for a change in supervision level or required transfer or commitment. The evaluation includes procedures for periodic follow-up assessment after the individual's discharge from suicide precautions.

5) Housing. Unless constant supervision is maintained, a suicidal inmate is not isolated. Rather, he or she is housed in the general population, mental health unit, or medical infirmary, and located in close proximity to staff. All cells or rooms housing suicidal inmates are as suicide-resistant as possible (i.e., without protrusions of any kind that would enable the inmate to hang himself/herself).

6) Monitoring. There are procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained, usually every 15 minutes or more frequently if necessary. While there are several protocols for monitoring suicidal inmates, when an actively suicidal inmate is housed alone in a room, supervision through continuous monitoring by staff should be maintained. Other supervision aids (e.g., closed circuit television, inmate companions or watchers) can be used as a supplement to, but never as a substitute for, staff monitoring.

7) Communication. Procedures for communication between health care and correctional personnel regarding the status of the inmate are in place to provide clear and current information. These procedures also include communication between transferring authorities (e.g., county facility, medical/psychiatric facility) and facility correctional personnel.

8) Intervention. There are procedures addressing how to handle a suicide attempt in progress, including appropriate first-aid measures.

9) Notification. Procedures are in place stating when correctional administrators, outside authorities, and family members are notified of potential, attempted, or completed suicides.

10) Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides are detailed, as are procedures for reporting a completed suicide.

11) Review. There are procedures for medical and administrative review if a suicide or a serious suicide attempt (as defined by the suicide plan) occurs. See J-A-10 Procedure in the Event of an Inmate Death for details on these processes.

> **12) Critical incident debriefing**. The facility administrator specifies the procedures for offering timely critical incident debriefing to all affected personnel and inmates. Critical incident debriefing is a process whereby individuals are provided an opportunity to express their thoughts and feelings about a critical incident (e.g., suicide attempt, suicide), develop an understanding of critical stress symptoms, and develop ways of dealing with those symptoms.[4]

Finally, the U.S. Department of Homeland Security's *Operations Manual ICE Performance-Based National Detention Standards* requirements for a sound suicide prevention program mirror those of the NCCHC standards.[5]

Although correctional standards are generally not legally binding and do not set constitutional requirements, the U.S. Supreme Court has stated that such standards have the ability to serve as guidelines or benchmarks in assessing "duty of care" or "reasonable conduct."[6] With that said, numerous jurisdictions throughout the country are required through court-orders and/or settlement agreements to develop and maintain comprehensive suicide prevention programs in their jail, prison, and juvenile systems that include staff training, intake screening/assessment, safe housing, levels of observation, emergency response, and mortality reviews.[7] These program requirements are based upon national correctional standards.

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[4]Ibid. As a nationally-recognized expert in the area of suicide prevention in correctional facilities, NCCHC has regularly requested this writer's assistance in critiquing and revising this provision when the standards are updated every several years, as well as developed a guide for the development of suicide prevention policies which is contained as an appendix to each edition of the NCCHC standards and/or contained on the organization's website.

[5]U.S. Department of Homeland Security (2011), Immigration and Customs Enforcement, *Operations Manual ICE Performance-Based National Detention Standards*, Washington, DC: Author.

[6]See *Rhode v. Chapman*, 452 U.S. 337 (1981), *Bell v. Wolfish*, 441 U.S. 520 (1979).

[7]See the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997a et seq., and U.S. Justice Department's Civil Rights Division, Special Litigation Section: https://www.justice.gov/crt/special-litigation-section-cases-and-matters0#corrections. Several of these cases have involved county jails in Mississippi.

4) **Opinion Regarding Adequacy of Suicide Prevention Training Deferred**

Although suicide prevention training materials and staff compliance with such training were not available for review and any final opinion regarding the quality of any such training by the CCSO would be deferred at this time, any training that allowed detention personnel, including Sergeant Figueroa, to make a decision that an inmate engaging in self-injurious behavior, as well as having a prior history of suicide watch within the jail, did not warrant notification to mental health personnel for further assessment would be grossly inadequate, contrary to the standard of care, and reflect inadequate training. In addition, although both Officer Acuna and Sergeant Figueroa testified during their respective depositions that each had received some suicide prevention training, the quality of such training was questionable. For example, although it is commonly known through standard jail suicide prevention training that the vast majority of inmate suicides occur by hanging,[8] when asked during his deposition whether hanging was utilized in the vast majority of inmate suicides, Officer Acuna testified: "I have no idea" (at page 22).

[8]See, for example, Hayes, L.M., "National Study of Jail Suicides: 20 Years Later," *Journal of Correctional Health Care*, 18 (3), 2012; National Study of Jail Suicides: 20 Years Later, Washington, DC: National Institute of Corrections. U.S. Department of Justice, April 2010.

Finally, the only noteworthy information contained in the defense expert report of Scan Stewart was the inherent bias as reflected in the very first over-arching opinion (on page 29): "Jails typically house persons who are involuntarily confined, most of whom tend not to be honest, veracious, cooperative or compliant. Detainees are often uncooperative, unpredictable, deceptive, and manipulative." In addition, when describing Deputy Hogan's observation of Mr. Amaya's self-injurious behavior at both the Douglas substation and in the patrol car, Mr. Stewart stated (on page 42): "For lack of a better term, and based on my tenure in corrections, Deputy Philip Hogan regarded Reynaldo Amaya as having an 'Adult Temper Tantrum." Such inherent bias was deeply troubling.

Respectfully Submitted By:

/s/ Lindsay M. Hayes
Lindsay M. Hayes
October 13, 2018

EXHIBIT 5 on CD

EXHIBIT 6

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF COCHISE

* * * *

RAMONA AMAYA, mother of deceased, Reynaldo Amaya,

Plaintiff,

vs.

COCHISE COUNTY SHERIFF, Mark Daniels,

Defendants.

NO. CV201600305

DEPOSITION OF:

TROOPER PHILIP HOGAN

Globe, Arizona
April 23, 2018
10:00 a.m.

* * * * * * * *

COLVILLE & DIPPEL, LLC
REPORTED BY: Pamela L. Lohr, RPR
Arizona Certified Reporter 50035

A. Yes, sir.

Q. So the drive to the station is on the Puma still?

A. Yes, sir.

Q. How long does that recording go at the station? Does it record everything that occurred at the station?

A. If I remember correctly I -- there's a pause button on the recorder, so once he was placed into the cell the pause was initiated. And then when I went in to talk to him the pause was reinitiated which allowed it to begin recording again.

Q. This is the Puma?

A. This is the Puma.

Q. So he indicated that he was willing to talk to you. And what was the conversation about?

A. I began the conversation with him acknowledging if he knew he had a restraining order or a order of protection, and at one point he said he did. He remembered coming to the Douglas office and signing the order of protection and he didn't remember what day it was.

He then asked me what he was going to be charged with. I told him that I'm waiting for his criminal history. At which point he said he didn't want to talk to me until he found out what his charges were.

Q. Okay. Then you received, from Bianca Wiggins,

the 29 text messages that Amaya had sent to her during that recent period, correct?

A. Yes. Well, he was -- at that point he said he was done talking with me until we figured out what his charges were. I had contact with Bianca and asked her for those text messages and the phone calls that she said he called. And that's when I received the 29 separate messages and, approximately, 86 phone calls.

Q. And I'm sure you processed those. Deputy Clark, finally, got the prior criminal history on Mr. Amaya?

A. Yes, sir.

Q. And then you went back in to speak with him?

A. Yes.

Q. What happened when you went back into the cell?

A. When I went back into the cell Amaya began to hit himself in the head with the wrist of the handcuffs trying to cause physical harm to himself.

Q. Let me stop you. Did you say anything to him before he started hitting himself? Did you give him the criminal history?

A. If I can look at my report just a second just to make sure. I went in to speak with him and he began to hit himself, so I never actually told him what was going on.

Q. Okay. He began to hit himself in the head with

handcuffs?

A. Yes, stating to me that he was going to start hitting his head on the wall, at which point I went hands-on with him and switched the handcuffs from the front to the rear so he wouldn't hit his head and he was secured into my patrol unit.

Q. Was your patrol unit pulled into a bay area or something there at the sheriff's station?

A. Just that parking lot, that secured parking lot in the video.

Q. So you took him out of the cell and put him into the patrol unit?

A. Yes. And the reason we use the patrol unit is -- I was a K-9 deputy down there so the prisoner compartment there is a tight compartment, so for him to bang his head or do anything, it's a little harder to do versus having free range of an open office.

Q. Do you recall how many times that he hit himself with the cuffs?

A. I do not recall. I know it was more than twice because on the second or third is when I grabbed his hands because that's how many steps it took me to get into the room.

Q. Did he also, once you put him into the prisoner compartment of your patrol unit, did he bang his head

against the sides of that unit?

A. Yes, multiple times, and he refused to stop.

Q. Did he tell you why he was doing it?

A. He stated to me that he didn't give fuck. He was still going back to prison. He continued to hit his head and then stating he would fuck himself up more and he did this shit on purpose, is what he stated to me.

I contacted assistance in this case to have somebody watch him while I completed the booking paperwork and a Douglas police officer later arrived at our office and sat with him while he was in the backseat of my patrol car.

Q. Did he sit in the backseat with him?

A. No. He stood on the outside while he sat in the seat, seat-belted in.

Q. So he stood on the outside and what did he do then on the outside? Did he prevent Amaya from hitting his head or --

A. Yeah, he spoke with Amaya and kept him from hitting his head on the patrol car.

Q. What did -- so you completed the booking process at that time?

A. Yes.

Q. Once you completed that paperwork what happened?

A. I transported him to the jail at Bisbee.

requested that someone be standing by for your assistance and a suicide watch for Mr. Amaya?

A. I honestly don't recall, but if this is a text message from Roger, then I most likely received it.

Q. At the top it says "Monday, June 15 at 12:56 a.m." At that time what would you have been doing?

A. 12:56? So that would have been part of the booking paperwork at the office.

MR. AUDILETT: Which office?

THE WITNESS: I'm sorry. No. That would be while I was en route to the jail from the office, from the Douglas office.

BY MR. HICKS:

Q. Okay. Below that it says "TNK." Do you know what that would signify?

A. "Thanks."

Q. Would that be something that you would texting back?

A. That would be something similar to that. Yes, that would be something similar.

Q. And do you recall anything about the next part there, "hey, late 28 return, the ATL truck has multiple lane crossings, better late than never"?

A. I do not recall.

Q. Okay.

the report.

Q. When you or the person -- other deputy that is working with you advises the jail that they might need to do a suicide watch on the person coming in, is that something that your rules or your regulations would require you to put into a report?

A. No, not with the sheriff's office. Again, it could be in a supplement from Deputy Clark, but it was not in my report.

Q. When you arrived at the jail, assuming this is a text message to you from Deputy Clark, when you arrived at the jail, did you or do you recall assuming they were aware of what Deputy Clark had told them?

A. It's unknown.

Q. You don't recall?

A. I don't recall.

Q. Do you recall what happened when you got to the jail, what physically happened?

A. As far as we all walked in to the booking area, the booking information was taken off my thumb drive. I utilized on the booking computer, information was taken off and was given to the jail staff and I left.

Q. So that information that you -- your booking information that you had filled out in Douglas was taken off of your thumb drive and given to the jail staff?

the report.

Q. When you or the person -- other deputy that is working with you advises the jail that they might need to do a suicide watch on the person coming in, is that something that your rules or your regulations would require you to put into a report?

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A. As far as we all walked in to the booking area, the booking information was taken off my thumb drive. I utilized on the booking computer, information was taken off and was given to the jail staff and I left.

Q. So that information that you -- your booking information that you had filled out in Douglas was taken off of your thumb drive and given to the jail staff?

A. Yes.

Q. And they would have downloaded it onto a computer they have?

A. I downloaded it from the computer onto the form and in the paperwork is the booking form.

Q. So you printed out the paperwork?

A. Yes.

Q. How long were you at the jail after you brought Mr. Amaya in?

A. I don't know if they have the calls -- I don't recall. I know it wasn't long, I don't believe.

Q. So just to recount, Mr. Amaya, when you first handcuffed him, began hitting himself in the head with the handcuffs?

A. Yes, sir.

Q. And that continued until you put his handcuffs behind his back?

A. Yes, sir.

Q. And then you put him in the -- he began hitting himself in the cell, his head against the cell wall or the cell bars?

A. No. He stated that he was going to start hitting his head in the cell and that's why he was taken out to my patrol car and secured in the patrol car.

Q. So he did not hit his head in the cell?

A. Yes.

Q. And they would have downloaded it onto a computer they have?

A. I downloaded it from the computer onto the form and in the paperwork is the booking form.

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Q. And then you put him in the -- he began hitting himself in the cell, his head against the cell wall or the cell bars?

A. No. He stated that he was going to start hitting his head in the cell and that's why he was taken out to my patrol car and secured in the patrol car.

Q. So he did not hit his head in the cell?

A. No, he didn't.

Q. I thought you had said that he hit himself a couple of times before you could get to him?

A. Not on the walls, but with his handcuffs.

Q. Okay.

A. Because you were saying "hit his head on the walls," and it was the handcuffs he was hitting himself with.

Q. In the cell?

A. In the cell, yes.

Q. Okay. Then when he was put in the patrol car he continued to bang his head against the patrol car walls?

A. Yes, sir.

Q. You had a Douglas deputy report to the sheriff's department to talk to him and watch him while you completed the paperwork?

A. Yes, it was a Douglas P.D. officer and, yes, he stood outside with him in the back of the patrol car.

Q. Do you recall who the PD's officer was?

A. I don't recall.

Q. Would you have in it your report?

A. I should have put it in there, but the name's not there. It just states a Douglas PD officer.

Q. Okay. And then you transported Mr. Amaya to Bisbee and on the way it appears that Roger Clark advised

is.

Q. Did you prepare that?

A. Yes, sir.

MR. HICKS: Okay. That's all the questions I have.

MR. AUDILETT: Let me ask just a few.

E-X-A-M-I-N-A-T-I-O-N

BY MR. AUDILETT:

Q. I recall hearing on the audio of the video him banging his head. And you heard that?

A. Yes.

Q. Of course, you experienced that, right?

A. Yes.

Q. And I hear you saying, "knock it off." Right?

A. Yes.

Q. He doesn't right away, but pretty quickly he does, doesn't he?

A. Yes.

Q. And that's when you called the Douglas PD guy to stand by him while you do what?

A. Complete the paperwork, booking paperwork.

Q. Okay. I also recall a conversation, I think with Mr. Amaya and the Douglas police officer, and he is complaining that the handcuff is too tight on his wrist?

A. Yes.

Q. Do you remember that?

A. Yes.

Q. You heard that?

A. Yes.

Q. Were you there to hear that or you have just heard it on the audio?

A. I heard it on the audio.

Q. And he complains that it's hurting his wrist because his wrist was previously injured?

A. Yes. And I use a hinge-type handcuff, so if you did have wrist injuries they're on the correct way, however, they're not made to be comfortable.

Q. Right.

A. And they might have just been twisting his wrist just a tad to make it uncomfortable for him.

Q. Fortunately, I have never had to experience that. But he indicated that he had pins or something in his wrist where it was previously broken.

A. Yes. He stated to me that he had been shot in the hand and had pins in his hand.

Q. Okay. And the Douglas PD officer complied with his request?

A. Yes, sir.

Q. And loosened the cuff?

A. Listening to the audio you can hear him step out

EXHIBIT 7

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF COCHISE

* * * * *

RAMONA AMAYA, mother of deceased Reynaldo Amaya,

Plaintiff,

vs.

COCHISE COUNTY SHERIFF MARK DANNELS,

Defendant.

Case No. CV2016 00305

. . . . . .

DEPOSITION OF ROGER CLARK

10th day of May, 2018

Sierra Vista, Arizona

. . . . . .

COPY

COLVILLE & DIPPEL, LLC
Colville & Dippel No. R1129
REPORTED BY: G. ALLEN SONNTAG,
Certified Reporter No. 50194
File No. 62618-1

Sheriff's Deputy or as a Douglas Police Officer where Reynaldo was suicidal prior to this incident?

A I don't believe so.

Q Were you aware that he had suicidal tendencies in an arrest that occurred in 2012?

A I recall hearing something but nothing specific, nothing that I can recall by memory, who may have said what, other than him being mad or something, him having issues at a prison, I believe it was, or something to that effect.

Q Now, was that something that you heard after he passed away or before?

A I believe it was -- I'm going to have to say that was before.

Q Okay. So do you recall what you had heard, other than just prison issues?

A If I remember correctly, it was Sergeant -- he is now a Sergeant with us -- Sergeant Louie Tartaglia, T-a-r-g-l-i-a.

Q T-a-r-t-a-g-l-i-a?

A G-l-i-a.

Q Yeah, okay. And what did Sergeant Tartaglia tell you?

A Not verbatim but approximately something to do with, when he used to work, he being Sergeant Louie

Tartaglia -- when he worked at the State prison, he recalled having some information of something at the prison where he was pretty much, in a nutshell, not welcome back by other prisoners.

Q He had had a hit out on him?

A Something to that effect, yes, sir.

Q Were you aware of the incident where Reynaldo was shot by another person in -- I don't recall the exact time frame but somewhere around 2012?

A I don't recall the time frame but I do recall there being something where he had been shot and by some guy they called Cheech, C-h-e-e-c-h.

Q And do you know if it was Cheech who had put out the hit on him at the State prison?

A I don't know.

Q Were you aware that Reynaldo testified at the trial, Cheech's criminal trial?

A Yes.

Q And did you make the connection, that it was Cheech who had put the hit out on Reynaldo at State prison?

A No.

Q But you had heard something about that Reynaldo wasn't welcomed back to the prison by, at least, some inmates?

A At least by someone, yes, sir.

Q Okay. And did you ever talk to Reynaldo about that?

A I believe one time there was a conversation with him, which took place at the alleyway of the old Cochise County Sheriff's Substation in Douglas, Arizona.

Q Could you tell me about that?

A The conversation?

Q Yes.

A I just recall asking him, "Hey, how are you doing? Are you okay"; and, once again, nothing verbatim but something to that effect, "Are you okay," and everything else.

I recall him showing me a wound, I believe, on his stomach area -- I don't recall where -- and I asked him, "Well, you better make sure you take care of that," something to that effect.

And then is when he told me that Cheech -- I don't know his full name -- was found guilty in Superior Court.

Q Of shooting him?

A Of shooting him, that's correct.

Q And shooting his girlfriend, also, didn't he?

A There was someone else who got shot that same

A I was outside. I then left, went outside to the parking lot.

Q Okay. What did you next observe as far as Reynaldo?

A I did not observe nothing on Reynaldo.

What I do recall is hearing over our police radio where Deputy Hogan -- by the way, I'm trying to speak slow enough, so you folks can write your notes

MS. BERNSTEIN: Thank you.

THE WITNESS: Do I need to slow down a little bit or is it --

MR. HICKS: You are doing fine.

MS. BERNSTEIN: Yes, you are fine.

A (Continuing.) I want to help you guys out as much as I can.

With that said, I recall hearing Deputy Hogan over police radio say that he was hurting himself, Reynaldo, inside the cell.

I immediately ran into the backdoor; and as soon as you walk in through the backdoor, I could see the detention cell door propped open.

So I immediately went in and I looked and I recall seeing Deputy Hogan. He either just finished handcuffing him or something, and at that point I recall seeing Reynaldo. I looked at him and I recall

seeing him where like his forehead area was red.

And the reason I clearly recall that is he is really fairly light skinned; and I recall seeing that and I recall what Deputy Hogan had said over the radio, something to the effect that he was hurting himself or something to that effect.

BY MR. HICKS:

Q Okay. So what happened then?

A At that point Deputy Hogan said something about, "I'm going to secure him in my vehicle for now."

And I said something about, "You may want to just head over to the jail now, somewhere where he can be safe and secure."

Q Okay. What happened then?

A Excuse me. I'm sorry. What was your question, Counsel?

Q Did he secure him in the vehicle and then come in and complete his paperwork?

A Actually, if we can go back just a bit before that.

Q Okay.

A I recall when I was out there, Deputy Hogan had also called and requested a Douglas police officer for assistance. I don't -- I don't recall. I want to

say it was Officer Lomeli, Michael Lomeli. Lomeli is L-o-m-e-l-i. I believe he is the officer who showed up to watch him.

I wanted to kind of stand away from Reynaldo, even though, when Reynaldo was in the cell so Deputy Hogan had secured him, I told him, "Don't hurt yourself, Dude. Calm down. Relax. Calm down." I recall telling him that.

I did not see him hitting himself in any way whatsoever. I was just telling him that, taking Deputy Hogan's word that he had been trying to hurt himself and then after entering and seeing the bright red, the redness, on his forehead.

Q Okay. So then what do you remember next?

A I recall Deputy Hogan's marked patrol unit parked backwards like this. I recall it back this way, with the front end facing south in our back parking lot; and Deputy Hogan placed him behind the rear driver's side of his patrol vehicle. (Indicating.)

I don't know if he moved him later or not but I recall him sitting there, and the Douglas police officer was asked to watch him.

And then the officer -- I remember the officer stayed there and maintained watch of him while

I spoke with Deputy Hogan.

Q Okay. What was the conversation between you and Deputy Hogan?

A I asked him, "Are you done?" It was something to the effect, "Are you done with your paperwork? If not, I will complete it for you. You need to run. Get out of here. Take him up to Bisbee."

Q And what was his response?

A I recall him saying something to the effect of, "Yes, yes. I'll leave now."

I don't recall if he finished his booking paperwork or if I did it for him.

Q Okay. Do you recall any -- seeing Reynaldo harming himself while he was in the vehicle parked outside with the Douglas officer watching him?

A Actually, I do. I heard a large -- I'm sorry -- a loud hit against the window; and I looked and I recall looking that way and his head was moving away from the window. By his head, I'm referring to Reynaldo's head.

Q Okay. When did that occur, more or less, while you were talking to Deputy Hogan?

A I don't recall if I was talking to Deputy Hogan or to the police officer at that time.

Q What's the next thing that you recall that happened?

A I recall Deputy Hogan leaving our secured parking lot with Reynaldo and I recalled going into the office and using a landline just to call direct, because within our agency we can call direct to any substation or jail.

I recall calling the jail, the Bisbee detention center, and I recall speaking to a detention Officer Acuna, A-c-u-n-a. I don't recall his first name.

Q Okay.

A Something with a B, I believe.

MR. AUDILETT: Benjamin.

THE WITNESS: Benjamin, Benjamin.

BY MR. HICKS:

Q So you called him from the landline there at your substation and you spoke directly with Officer Acuna?

A Detention Officer Acuna, that's correct.

Q Okay. What was the content of your conversation?

A I recall advising him to place -- first of all, let me back up.

I recall telling him that Deputy Hogan was in

route to the detention center with an arrested subject.

I advised him to place the subject on watch.

Q On suicide watch?

A I believe more specifically suicide watch is what my wording was.

Q What did Officer Acuna say?

A I'm going to say guess and say okay or yeah.

MR. AUDILETT: Don't guess.

THE WITNESS: I'm sorry?

MR. AUDILETT: Go ahead. We try not to guess.

THE WITNESS: Okay. I'm not sure if it was, okay or yes, one of those two.

BY MR. HICKS:

Q But it was an affirmative answer?

A Correct.

Q And did you explain to Detention Officer Acuna why you were making that request?

A I said something to the effect of what Deputy Hogan had stated over the radio at that time. I don't recall the exact verbiage, but something to the effect that he had been hitting himself.

Q Do you recall anything else that was said in that conversation?

A I don't recall anything else. Here is your Exhibit 1 back, sir. (Indicating.)

Q Thank you. Do you recall at some stage Officer Acuna asking you why the suicide watch and you respond something like, "Someone banging his head that hard needs to be watched closely?" Do you recall something like that?

A That sounds about right.

Q And at that time did you text Deputy Hogan, telling him, "I advised detention of his actions and requested someone standing by for you at a suicide watch for him?"

A I don't recall the exact verbiage, but that sounds about right.

MR. HICKS: Will you mark that.

MR. AUDILETT: Can you show me quickly what you were reading from right now?

MR. HICKS: What I was reviewing --

MR. AUDILETT: No; what you were reading from.

MR. HICKS: Okay.

MR. AUDILETT: I know I have seen it; but --

MR. HICKS: I don't have an extra copy of that.

MR. AUDILETT: That's all right.

(Document marked as Clark Deposition Exhibit No. 2 for identification, 10th day of May, 2018.)

BY MR. HICKS:

Q Let me show you what has been marked as Exhibit 2 and see if you recognize the document or the content of the messaging in the document.

A Yes, sir, I do, on Exhibit 2.

Q Does that appear to be a text message between you and Officer Hogan?

A Yes.

Q And do you recall making that text message to Officer Hogan?

A I did this, yes, correct, to Deputy Philip Hogan.

Q And you advised Deputy Philip Hogan that you had requested someone standing by for you, meaning standing by for Deputy Hogan, and a suicide watch for him, meaning Reynaldo Amaya?

A Yes.

Q And it appears that Deputy Hogan received the message, because he put a T-N-K on there, which would mean thanks?

A I'm assuming, yes. Deputy Hogan had his ways of butchering messages. I'm going to guess and say

Mon, Jun 15, 12:56 AM

I advised detention of his actions and requested someone standing by for you and suicide watch for him

Exhibit No. 2
Date: 5-10-18
CLARK

Tnk

Hey late 28 return the atl truck has multiple lane crossings bettee late than never

Lmao

U office

Yup

Want anything to drink

Text Message

Send

EXHIBIT 8 on CD

(see disc in Exhibit #5)

EXHIBIT 9

COCHISE COUNTY SHERIFF'S DEPARTMENT
Narrative Report

DISTRIBUTION:

CCSO Records

SYNOPSIS:
On 06-14-2015 Reynaldo AMAYA DOB 02-22-1983 violated a Valid Order of Protection when he contacted Bianca Wiggins DOB 02-14-1980, AMAYA contacted Wiggins by text 29 separate occasions on this day. AMAYA also called Wiggins approximately 86 times in a 7 hour period on todays date. Prior to CCSO Deputies arrival AMAYA told Wiggins Don't do this you will make me do something crazy and he did not care if he went to prison and he would kill her too. This was stated to me by Wiggins. AMAYA later turned himself in and refused to complete an interview which was started by him becoming violent and injuring himself. AMAYA was later transported and booked into the CCSO Jail and booked for the following;

ARS. 13-3601.02.A	Aggravated Domestic Violence Felony
ARS. 13-3601/13-2921.01.A1	D/V Aggravated Harassment Felony
ARS. 13-3601/13-2916.A3	D/V Use of Electronic device to harass Misd.

NARRATION:
On 06-14-2015 at approximately 1950 hours, I was dispatched to 2173 E 20th St. in Douglas reference to a Reynaldo AMAYA DOB 02-22-1983 violating a court order against Bianca Wiggins. It should be noted that there is a valid order (OP) out of JP2 #J-202-CV-201500277 stating AMAYA to have no Contact with Wiggins. The order was served on 06-11-2015 at 1130 AM and was signed by AMAYA.

Upon arriving on scene I spoke with Wiggins, while speaking with Wiggins AMAYA called on more than 4 separate occasions after Wiggins told him to stop calling her. Each time AMAYA called and we told Wiggins to answer we recorded the conversation. The conversations were recorded Via my MVR in my patrol unit. When AMAYA called he used pronoun words and spoke between English and the Spanish Language.

I was told by Wiggins that today AMAYA stated to her Don't do this you will make me do something crazy and he did not care if he went to prison and he would kill her too. While I was at the home of Wiggins the calls from AMAYA lasted from 30 seconds to over a minute. Each time the call came in with AMAYA on the line the number came up "Restricted." See Item #1122-1 recording for the time of 20:05:20 to 21:04:40 (1st recording) for what was said via the phone calls as it is also in the Spanish Language and I am unable to translate the Spanish Language into the English Language.

I told Wiggins I would go out and look for him and if he does come here to call 911 and we would return. One more call came into the phone as I was leaving I had Wiggins answer the phone. In the back ground noise in the Spanish Language (translated to me) someone was asking for Ice. Due to Deputy Clark whom arrived on scene later having dealt with the same two people in the past he advised me AMAYA was at the Best Western Motel in the past and may still be there.

We left the home and as I showed up at the motel, CCSO Dispatch patched a call

to me from AMAYA. The voice was the same voice which was calling Wiggins. AMAYA asked what was he being charged with. I told him as of right now Violation of a Court Order. He asked me what does that carry. I told him Violation of Court Order carry Misd. charges. AMAYA stated he would turn himself in after he got something to eat and he would call me back. He asked when I got off of work and I told him I go home at 10 PM (as I did not want to wait all night for him to

make his mind up) AMAYA stated he would call back. See Item #1122-1 from the time of 21:18:45 to 21:21:21 (2nd recording) for this Audio recording of the contact.

Deputy Clark and I walked the Motel and did not located him. We cleared and continued to look for him. At 2154 hours, a call was patched to me again and it was AMAYA stating he was at the Boarder Mart waiting for me. I told him I would be there shortly. I arrived at the Boarder Mart and he was not present. At 2203 hours, a call was patched to me again from CCSO Dispatch and it was AMAYA stating he was at the Circle K in Douglas and he would turn himself in now. The MVR at this point was not recording and the Puma Recorder was being utilized see the Puma Recordings which will later be downloaded to the Puma Server.

I met with AMAYA and his voice matched the phone calls that were received by Wiggins when AMAYA called when I was on scene at Wiggins home. I detained AMAYA into handcuffs in the front of his body as he stated he had an hand injury. I drove AMAYA back to the Douglas Office where he was read his Miranda Rights. AMAYA stated he under stood his rights and he would speak with me. I asked when did he get served with the order. AMAYA stated he did not remember but stated he came to the Douglas Office and was served. I asked him if he knew the order was valid at which time he asked me what he was being charged with and I told him I was waiting on his criminal history report and I would find out then. AMAYA stated he did not want to talk until he knew all the charges he was faced with. I told him I would return once I found out all the charges. It should be noted that AMAYA was searched for weapons and he had no property and he had even removed his belt prior to meeting with me. This conversation was recorded on the Puma Digital Recorder and was later downloaded to the Puma Server see the audio for further details in the interview.

I called Wiggins and asked her to send me the text messages via my work e-mail and along with the call list of the calls from AMAYA. At this time I was waiting for this information so I could determine the charges at the request of AMAYA before he would speak with me.

I received from Wiggins 29 separate text messages which Wiggins stated were from AMAYA. The time on the text messages started today at 1:59PM to the last message being at 9:44PM (06-14-2015). In one of the last text it states at 9:26PM "R u happy i already talked to the sheriff Im gonna turn my self in" this message was tested after AMAYA spoke with me over the phone. See copies of the Text Messages attached on 6 separate pages.

I also received from Wiggins a copy of the approximate 86 times AMAYA called her today from 3:05PM to 9:48PM. I was told the Name Majo (520-249-4312) was the name she had for AMAYA. A copy of this will be added and it is on 11 separate pages.

Deputy Clark had requested a Criminal History on AMAYA and upon getting the information and the criminal history showed 06-12-2015 Assault D/V Dispo Guilty,

12-07-2005 Disorderly Conduct D/V Dispo Guilty, 12-07-2005 Threat- Intimidate D/V Dispo Guilty, 02-24-2006 Threat- Intimidate D/V Dispo Guilty, 01-17-2012 Aggravated Domestic Violence (D/V) Dispo Guilty, in which he already Served 2 years in DOC.

I went in to speak with AMAYA and he began to hit his head with the handcuffs and state he would start hitting his head against the walls. He was detained in the handcuffs behind his back at this time and secured in my patrol unit where

he began to hit his head in the metal prisoner compartment. Stating he did not give a fuck he was still going back to prison. He continued to beat his head against my patrol unit he was told to knock it off and he refused. AMAYA stated he would fuck himself up more he did this shit on purpose. AMAYA refused to talk to me One Douglas PD Office was contacted to assist me in watching the AMAYA so I could complete the jail paperwork for booking. Once I completed the paperwork and AMAYA was later transported to the CCSO Jail in Bisbee and booked for the listed charges. The incident with AMAYA becoming violent mostly to himself was recorded both on the Puma Recorder and My MVR in my patrol unit from 23:46:15 to 01:08:25 (the 4th recording), see both of the recordings for his actions and what was said.

Deputy Clark later assisted me with Serving the Victims Rights for for me to Wiggins.

The MVR recording was later logged into Evidence and the Puma Recording was downloaded to the Puma Server. It should be noted as I was completing the report I observed in CCSO Jail Booking AMAYA has an AKA of "MAJO".

STATUS:
Case Closed with one Adult Arrest

ATTACHMENTS:
CCSO Booking Sheet (3 pgs)
Copy of OP #J-202-CV-201500277 (6 pgs)
Victims Rights #C377490
TEXT Messages (6 pgs)
CALLS (11 pgs)
48 Hour Case Request fax (3 pgs)
Copy of CCSO Evidence Sheet Item (1122-1 MVR Recording)
Copy of CCSO Evidence Sheet Items (1122-2 Puma Recordings)
Copy of CCH Request

MVR:Yes Evidence 1122-1
DIGITAL IMAGES:None
AUDIO RECORDINGS: Yes Evidence 1122-2

Date, Time, Reporting Officer:
P. Hogan #1122 Tue Jun 16 01:40:59 MST 2015

Date, Time, Reviewed By:

EXHIBIT 10

COCHISE COUNTY JAIL MEDICAL

MEDICAL INTAKE SCREENING

DATE 6/15/15 TIME 1:20 LMP N/A

INMATE NAME AMAYO, Reynaldo DOB 2/22/83

WEIGHT 191 BP 131/88 P 88 TEMP 97.4 PULSE OX 98%

DO YOU HAVE ANY OF THE FOLLOWING:

DIABETES Y N SEIZURES Y N HEART DISEASE Y N HIGH BLOOD PRESSUE Y N

ASTHMA Y N LUNG PROBLEMS Y N OPEN SORES Y N LIVER PROBLEMS Y N

HEPATITIS Y N DENTAL PROBLEMS Y N BLADDER/KIDNEY PROBLEMS (Y) N

HEAD INJURY Y N STOMACH PROBLEMS (Y) N MUSCLE/BONE PROBLEMS (Y) N

ALLERGIES Y N REACTION:_____ HIV/AIDS Y N PREGNANT Y N

OTHER MEDICAL PROBLEMS Y N

COMMENTS ON YES ANSWERS

Kidney Stones

injury from gunshot to colon- hard time having B.M. - uses "fiber"

screws in (L) wrist

ARE YOU PRESENTLY TAKING PRESCRIPTION MEDICINE Y N

Naproxen - OTC

fiber - OTC

PHARMACY_____ PCP_____

HAVE YOU HAD SURGERY, INJURY OR HOSPITALIZED IN THE LAST YEAR Y N

DO YOU REQUIRE A SPECIAL DIET (Y) N high fiber

CC 5

DO YOU USE TOBACCO Y N

DO YOU USE STREET DRUGS Y N

ALCOHOL USE Y N

HAVE YOU HAD ALCOHOLIC SEIZURES OR DT'S Y N

HAVE YOU EVER ATTEMPTED SUICIDE Y N

ARE YOU THINKING OF HURTING YOURSELF Y N PLAN Y N

HAS ANYONE IN YOUR FAMILY ATTEMPTED OR COMITTED SUICIDE Y N
uncle 1993

ARE YOU TAKING ANY MEDICATION FOR EMOTIONAL OR MENTAL HEALTH PROBLEMS Y N

HAVE YOU EVER BEEN IN A HOSPITAL FOR EMOTIONAL OR MENTAL HEALTH PROBLEMS Y N

ARE YOU CURRENTLY WITH AN AGENCY FOR MENTAL CARE Y N

CASE MANAGER_____ AGENCY_____

ANY RECENT TRAVEL OUTSIDE U.S. Y N IF YES, WHERE_____

MEDICAL INSURANCE ACCHS

FOLLOW UP_____

✓ ***INMATE UNDERSTANDS PROCESS TO OBTAIN MEDICAL CARE WHILE INCARCERATED***

INMATE SIGNATURE

MEDICAL SIGNATURE

EXHIBIT 11

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR THE COUNTY OF COCHISE

* * * * *

RAMONA AMAYA, mother of deceased, Reynaldo Amaya,

Plaintiff,

vs.

COCHISE COUNTY SHERIFF MARK DANNELS,

Defendant.

Case No. CV2016 00305

. . . . . .

DEPOSITION OF BENJAMIN ACUNA

10th day of May, 2018

Sierra Vista, Arizona

. . . . . .

COPY

COLVILLE & DIPPEL, LLC
Colville & Dippel No. R1129
REPORTED BY: G. ALLEN SONNTAG,
Certified Reporter No. 50194
File No. 62618-2

Q If Officer Clark had told you that Mr. Amaya needed to be placed on a suicide watch, what would you have done?

A What would I have done?

Q Yes.

A In most cases like that, I probably would have placed him on a watch if he is specifically saying he needs to be on a suicide watch.

Q Was it your responsibility to make the decision to place Mr. Amaya on suicide watch or put him into another population?

A Are you talking about --

Q Is that your decision or is that Officer Figueroa's decision?

MR. AUDILETT: Sergeant Figueroa.

MR. HICKS: Sergeant Figueroa's decision.

A Anyone can initiate a suicide watch, a special watch, regardless of --

BY MR. HICKS:

Q Have you initiated suicide watches as the booking officer?

A Yes.

Q So if I'm understanding correctly, if Officer Clark had -- if you had understood him to say he needed to be placed on suicide watch, you most likely

to a possible combative.

When we opened the door -- I believe it was Sergeant Figueroa who opened the door -- he seemed to be completely the opposite, seemed to be in good spirits.

Q Not combative?

A Not combative at all.

Q So what happened then?

A We started going through the booking process.

Hmmmm. I remember both me and Sergeant Fig asked me several times, because we do know that he did hit his head against the wall down at the substation; and we asked him why he did that and was he going to do it again.

He stated that he did that because the deputies were not allowing him to use the restroom, they weren't allowing him to have any water and that's why he was doing that there.

And that when he came, he had even -- so he peed his pants before he even got here because of that.

Q Did you speak with detective -- err, Deputy Hogan about Mr. Amaya, what he had observed about Mr. Amaya and what his perceptions were?

A I didn't really speak with him that much. It

was just a matter of the booking paperwork as far as Deputy Hogan was concerned.

Q Did he bring booking paperwork?

A I believe he was doing the booking paperwork at the booking area.

Q Okay. So what did you do? Once he got out of the vehicle and he was no longer combative, what happened next?

A We continued with the booking procedure.

Q And what is the booking procedure?

A A series of different tasks I need to perform to intake them into the jail.

Q Just take me through it briefly.

A There is a booking checklist that we go through. We verify all their information, name, date of birth, particulars, you know, address, emergency contacts.

We take their pictures for identification purposes. We inventory their property, issue them out property.

If any holds need to be placed on them, we place those holds on them in our Spillman program.

Then we also enter their arrest, offenses and then we also conduct assessments on them as well.

Q You also do what?

Q Okay. Would you agree with me that you did not do the inmate intake assessment form?

A I would agree.

Q There are 16 questions on it.

A At least, that I didn't document it, not that I didn't do it. I'm sorry.

MR. AUDILETT: Say that again. I didn't hear it all.

THE WITNESS: That I didn't document it.

BY MR. HICKS:

Q If you did it, wouldn't there be some kind of a record of it?

A If I did it, it's a matter of documenting on my personal assessment on it. It's not a matter of doing the assessment. In most cases -- err, in some cases, you know, we do document it after the fact.

Q Is one --

A It depends on what station you are at.

Q Is one of the questions, "No. 2: Does the arresting officer believe the inmate is suicidal"; correct?

A Correct.

Q Did you ask Officer Hogan that question?

A Not outright, no.

Q Did you discuss with him that question?

A No, I did not.
Q Did you ask Officer Clark that question when he called in?
A I did not.
Q And you don't believe Officer Clark told you or requested you to put a suicide watch on Mr. Amaya?
A I don't recall him saying that.
Q Let me ask you: Had you had Mr. Amaya in the jail before?
A Me personally, no.
Q Well, had the Sheriff's Department had Mr. Amaya in the jail before?
A I believe they have.
Q And do you recall Mr. Amaya in the jail on previous occasions?
A No, I don't.
Q Do you recall -- in 2011 do you recall observing Mr. Amaya at times as a detention officer while he was under suicide watch?
A I do not.
Q What is your officer number?
A 848.
Q 848?
A (Indicating affirmative.)
MR. HICKS: If you could mark that, please.

Q What it means, okay.

A Yes.

Q It appears from Exhibit 1 that Mr. Amaya was in the jail in January of 2012, and at that time he was under observation because he had suicidal tendencies; correct?

A Correct.

Q Is there any way -- does the jail look up previous -- the booking officer, when people come in, do you look up previous jail visits to see if there's any kind of suicidal tendencies or anything like that in the inmate's past?

A I mean, we can, yes.

Q You have the ability to do that?

A Yes.

Q But you are not required by procedure to do it?

A I'm not sure if that's something that we can look into in a timely manner.

Q So it's not -- you don't know if it's right at your fingertips or not?

A Correct.

Q You don't know if there's a place in the computer to observe whether an inmate has had suicidal tendencies in the past or was under suicide watch in

the past?

A In most cases that would have to have gone -- you would have to search through the previous assessments done and it changes.

Q Okay.

A You will see an inmate one day showing or saying that he has had past attempts and the next time he's booked in on a later arrest, he will say that he has never once thought of it.

Q Do you recall asking Mr. Amaya, "Have you ever thought about suicide?"

A I recall that, yes.

Q And what was his response?

A He stated no.

Q Is that documented somewhere?

A I don't believe so.

Q Do you have any training of -- people who intend to commit suicide or are thinking seriously about committing suicide, do they tell people that they are intending to commit suicide?

A In some cases, yes; in some cases, no. It's -- there's not really any kind of known tendency for that.

Q It appears that Mr. Amaya, if he said that he was not thinking about committing suicide, that he did